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## ORIGINAL LECTURES.

### ON CERTAIN CUTANEOUS AFFECTIONS OF THE HANDS.

*A clinical lecture delivered at the Rush Medical College,*

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GENTLEMEN: By one of those singular coincidences with which we are made familiar in every public clinical experience, we have here presented to us for study several patients whose hands chiefly are affected with cutaneous disease. Let us begin by passing these cases in review; and then endeavor to understand the sign-language they are ready to teach us.

The first patient is a middle-aged woman in apparently fair health, who complains of an "itching humor which has been out for three weeks on the hands." She tells us that she does all the household work for her husband and three children. When we examine her hands, we observe that both organs exhibit a cutaneous disease, the right rather more than the left. The disorder has involved chiefly the dorsal surfaces and interdigital spaces. Here the integument is irregularly involved, in areas so indeterminate in outline that we could not map out the diseased surfaces with a pen or pencil. The limitation is most distinct as regards the palms, which are absolutely free from invasion. On the dorsal surfaces, chiefly about the metacarpo-phalangeal articulations, there is moderate thickening of the skin, which is of a dull reddish hue, and moreover raised so as to form papular elevations as small as poppy-seeds, very irregularly disposed upon the surface. Islands of sound skin, as indeterminate in outline as the patches of disease, can readily be distinguished here and there over the dorsal surfaces nearer the wrist. There is a little oozing from a few of the papules which have been torn in scratching, and this ooze has desiccated into a few thin and insignificant crusts on the right hand. The disease-process, you see, has extended slightly upward over the forearms, but ceases absolutely about the middle third of each. There is, however, at this limit of extension, no line of demarcation. Straggling papules of poor development, and less reddened patches gradually cease to show at this level; that is all. Her face, too, is reddened; its skin is slightly infiltrated, and she complains also of itching in this region. By passing the finger over its surface, you can here also detect a few very minute papules, and recognize the fact that the skin is here hotter than normal. The outline of the involved area is very indeterminate; we cannot say where the disease process begins and where it ends.

This affection we recognize without difficulty as an illustration of eczema, erythematous and papular in type. Our questions elicit the fact that she has been using a strong solution of washing soda in her laundry-tub, in order to save some of the labor of scrubbing her clothes with her hands; and this caustic solution, she admits, she has also used in washing her face. So much light, then, we have thrown upon the "humor of the blood."

The next patient is also an adult, a fireman, of vigorous appearance, whose hands are carefully wrapped up in greasy rags. He tells us that they have been giving him trouble for nearly a year; that no physician

has thus far been able to help him; and that he has no disease of the skin elsewhere. Now that they are uncovered, note how very differently his hands are involved from those we have just seen, not only as regards the site of the disorder, but also with respect to its behavior. The jealousy with which the palms were respected in that case is equalled in this by the absolute immunity of the dorsal surfaces. Here, on the right hand only, a single patch of disease slightly laps over the web stretching between the thumb and index finger, but in no other part is there any approach of the skin affection to the back of the hands.

Both palms, you observe, are involved, and nearly equally, almost symmetrically. Here we have a disease in distinct patches; we can map out each perfectly with a pen. The patches are of the size of half and whole silver dollars; some, nearly as perfectly circular; some oval; one, over the left hypothenar eminence, reniform or kidney-shaped. Look carefully at these curious disks, for each tells its story. In nearly every one, you can make out three levels. First, you see that the outer line of the disk is constituted of an apparently sound epidermis of the palm, clipped sharply and circlewise, as by a delicate pair of scissors, and slightly raised above the first level which it walls in. This rise of the apparently sound epidermis forming the wall, has slightly interfered with its vitality, for it has an unnaturally dead-whitish hue for a brief space around, and can be slightly raised from its bed with the finger-nail.

Next, proceeding towards the centre, is the first level, where is a younger and more tender epidermis, which, because it is thus young and tender, is unnaturally translucent, and permits the color of the inflamed derma beneath to modify its tint. This is why these disks have a dull purplish hue, and not the reddish shade of the hands we lately saw fresh from the laundry tub. But this new epidermis fails us as we pass to the centre of the disk, fails us very irregularly as to its width, but quite regularly as to its curved cuttings, over which we pass to a second level. Here is an epidermis still younger and still more tender, but yet an epidermis, through which, yet more clearly, we get a glimpse of the deep purplish and inflamed corium beneath. Lastly, in the centre, we reach a third and deepest level, which differs in different disks. In some, you see a glazing, over the engorged and empurpled derma; in others, the latter is fissured and oozing, the fissure extending in a straight crack across the disk, but always at nearly a right angle with the axis of the hand.

These palmar fissures annoy the patient more than any other symptom; and for this reason he has his hands so carefully tied up. He is a right-handed man, and he refers all his troubles to his handling of the hose-pipe when discharging his duties as a fireman.

But we are wiser than he in this matter, and indeed ought to be, seeing that these lesions tell us their own story without aid of his. Nothing but syphilis can explain such a pathological condition of the palms. No eczema, no psoriasis, no scabies, no lupus, no one of the long list of other cutaneous maladies, is ever characterized by the formation of these circular and oval disks, with their frayed epithelial walls and series of rising epidermal plateaux, with central ulcers or fissures. We are quite prepared to hear him therefore admit, as he does with some astonishment when he is

questioned upon that point, that he did have a sore on the genital region six years ago, followed by suspicious symptoms which were at the time "cured;" and that one of the first fruits of his subsequent marriage was an abortion on the part of his wife.

Our next patient is a healthy-looking man who approaches with his hands also carefully wrapped up, and who removes the dressings with extreme care. When exposed to view, we note that both organs are very extensively involved, the right more than the left. The palms are spared but the dorsal surfaces are pretty uniformly affected. The skin is tumid, and resembles a cushion on the back of the hand. The surface here is covered with pin-point sized vesicles, between which serum oozes from floors where evidently other similar lesions have formed and ruptured. Some of these vesicles have clear, others lactescent, contents. Here and there, sparsely found it is true, are small pustules evidently resulting from transformation of the vesicular lesions. A few light yellow crusts are seen on the region about the knuckles. The vesicular lesions extend to the interdigital spaces, where also the skin is swollen, hot and painful.

This is a case of dermatitis venenata. Our patient describes slightly bruising one knuckle of his hand with a hammer: and for the relief of the trivial resulting abrasion, he applied the tincture of arnica freely over the surface. He is sure that he spilled this over both his hands; and the dermatitis was in this way originated. Generally in such cases, the hands of the male carry the offending substance to the genital region, when the penis is handled in the act of micturition. This has been the result in this instance, the skin of the penis and scrotum being similarly affected, but to a decidedly less degree than that of the hands.

Let me say, in passing, that the poisonous action of tincture of arnica upon the skin is not generally appreciated. Dr. White, of Boston, was the first to publish an account of three cases in which this accident occurred (*Boston Med. and Surg. Journ.*, No. 3, Jan. 21, 1875, page 61), and Dr. C. W. Earle, of this city, has added an account of one interesting case. This is the second which has been presented at this clinic, a patient similarly affected having been shown to the class last year.

Here, finally, are two young men who come in together, and who tell us that they have been engaged at the same time upon the same kind of work. They were employed by some master-workman to put a certain species of coloring material upon the interior walls of a house, using for that purpose the broad brush of the "white-washer." In this way, they tell us that their hands chiefly, and, to a lesser degree, also, their faces, were spattered with the coloring solution, and soon after this accident the eruption appeared. As they sit together, side by side, you see that the four hands are affected, each to nearly the same extent. You notice also that the resulting lesions of the skin are somewhat similar to those we observed in the case of the laundress, and that the disease is the same, though rather more pronounced. The palms are spared. The backs of the hands; and, to a less extent, the wrists and the lower part of the exposed forearms, display light and dark-reddish, very irregularly outlined and slightly thickened patches of disease, with interspersed vesicopustules, papules, and delicate crusts. Equally ill-determined islets of sound skin are here and there interposed. The interdigital spaces are to a less degree involved. They complain of considerable itching. Notice particularly that in each man the right hand is more involved than the left, and that the disease is decidedly aggravated in the region of the thumb, the adjacent forefinger, and the intervening web. Each of these patients informs us that he is right-handed. Ob-

serve, also, that one of them has employed a flax-seed poultice over a portion of the hand, and that the diseased skin to which this application has been made is sodden, unnaturally white, and is also the seat of a few superficial erosions. In one place, a rather painful fissure has occurred, where the integument has been in this way weakened, and in its weakened condition put upon the stretch.

Let us now endeavor to understand the lessons which this series of diseased hands can teach us.

In the first place, with respect to the etiology of these affections, we observe that in one instance syphilis is accountable for the lesions; and that in all the others we have a satisfactory explanation in the operation of external agencies. And yet, when we study the hands of our syphilitic patient, we see that the systemic disorder is not alone accountable for the local distress. Here, none the less, we find that the constant handling of the wet hose used by firemen has greatly aggravated, and thus prolonged, the palmar affection. This lesson is so useful and important, that no one can safely ignore it. By the hand, more than by any other portion of his body, man comes in contact with the external world in his daily toil. What wonder, then, that it displays in the highest degree, the resentments which all such traumatic, poisonous, and other injurious contacts arouse! Here we have an epitome of the entire etiology of eczema. Did you ever think of it, the hands of an infant at the breast, hands unused in toil, are much less frequently affected with eczema and dermatitis, than those portions of its tender skin with which the hands of its mother or nurse have reason to be most intimate? Its scalp, irritated by an effort to remove the incrustated *vernix caseosa*, its buttocks covered by soiled napkins, and the neck, with which its clothing frequently comes into harsh contact, are in its case much more commonly involved. And if we go a step further, back to its uneventful life *in utero*, we discover that then it is absolutely and always saved from every accident which can endanger an eczema or dermatitis, as it floats in its warm water-bath, protected by its natural unguent from the macerative action of the surrounding fluid. If we are told that these disorders are due to a diathesis—rheumatic, arthritic, dartrous; if we are bidden to refer these maladies to preverted innervation, to assimilative debility, or to other equally indefinite causes, let us remember these striking facts. No child ever came into the world eczematous.

Notice, if you please, also, that in each case, our patients being all confessedly right-handed, that in each the right hand is most seriously involved, and that part also of the right hand which is most efficient in ordinary handicraft, namely, the thumb and index and the neighboring parts. How can any one whose patient exhibits these striking symptoms conceive for a moment that the skin disorder is one which originates from "impurities in the blood." If we go a step further, and inquire respecting the invasion of the palms in one class of cases and their immunity in another, we can receive an approximate answer only. Doubtless the reason why the backs of the hands are involved and the palms spared in the eczematous subject, is that the latter are relatively much thicker, and as a result much more fitted to resist the action of external irritants. Supposing that the latter exert an equal influence upon both planes of the hands, the dorsal surfaces naturally suffer first, because they are the more delicate in texture. That this is so, we are the more persuaded, because we do find very remarkable instances in which the palms alone are involved in eczema; cases, I should add, in which usually the parts chiefly affected have been long subjected to the action of a severe caustic or other irritant. In these rare instances

the surface is commonly symmetrically and diffusely involved, being abnormally reddened or even whitened, in consequence of the thickening of the epidermis, the resulting inextensibility often producing a species of semiflexion of the fingers toward the palm, and a proportionate difficulty in their complete extension.

If we next inquire why the palms alone are involved in the syphilitic patient, we are at a loss for a satisfactory explanation. Still, the very selection of a particular portion of the general surface of the body is a striking characteristic of many of the late syphilitic eruptions, and of not a few of those which may be regarded as early. The palmar and plantar syphilodermata occur both as early and late manifestations of the malady. This that you have seen is the late form, as we know, not merely by comparing the lesions with the date given in the patient's history, but also by inspection of the palms. The large size of the disks; the exfoliating lamellæ of epidermis, which have probably been chiefly responsible for the grave misnomer of "syphilitic psoriasis," applied to the disorder; and the deep fissures in an ulcerated condition which have formed centrally—those are not very like the more superficial, pea-sized, and merely desquamative lesions seen often within a few months after infection. To repeat, many of the late lesions of the disease are conspicuous for the selection of a special area: some linger near the nose; others at the anus; others, again, over the tibiae, the olecranon, or the patella.

Usually with a palmar syphiloderm we can discover a corroborative lesion in the mouth, the glands, or on some other portion of the body. Although there has been some doubt expressed upon this point, I am confident that cases occur where, after careful scrutiny, the hands alone are found to betray the evidence of syphilis in its objective symptoms. Pathologically, we know that the exfoliation and fissuring of the epidermis are accidents of the process. The disease really involves the derma, and it is only because the derma in this situation is covered by so dense an outer envelope that the phenomena are presented to us in this form. In the face, where the sebaceous glands are numerous, products of the syphilitic process may have a seborrhœic character; about the anus, where there is greater heat and moisture, vegetations often form; on the palms, dry, unprovided with sebaceous glands, and horny, naturally the thick epidermis plays a prominent part in the symptoms.

This much understood, the diagnosis and etiology of the several diseases of the hands are readily reached. Syphilis aside, there are few disorders limited to these organs which are not either forms of dermatitis or eczema, including under the latter term the eczematous lesions seen in scabies, a disease with an etiological difference. In the latter, we look to see a great uniformity of lesions, and, radiating from some of the pustules or vesicles, the little furrow or canalculus where the female *acarus* has tunneled her way beneath the skin and there deposited her ova. Scabies is rare in this city, and has been equally so in many of the Eastern towns of our country since the late civil war came to an end. But the increasing tide of immigration is, at last, restoring to our clinics a disorder familiar, indeed, to our fathers in medicine, but which was fast becoming to us a curiosity. You will be surprised to notice how many of the diminutive news-sheets published in this country during the early part of this century contain advertisements of remedies to cure "the itch."

Lupus erythematosus is occasionally seen upon the hands. I showed a young lady to the class, a few months ago, with a characteristic patch of the disease upon one hand; and the late Dr. Fox, of London, in his plates, gives an illustration of the affection as it occurs upon the same organ. It decidedly prefers the

dorsum of the hands, and spreads here rather more actively than upon the face, doubtless in consequence of the freer movements and accidents of contact of these organs. It is for precisely that reason, I suspect, that it tends to run up to and encircle the thumb, often spreading at one border while it leaves at the other its characteristic scar, the most elegant of all cutaneous scars. This is smooth, uniform, unattached and punctate, suggesting the action of the engraver's tool in what they term the "stippling" process. By many of its characteristic symptoms you can here recognize it: Its attached scales, often worn off from the hand, it is true; its deeper than light-reddish shades; and its frequently roughened, well-nigh ichthyotic aspect, when it has occurred on the hand of the seamstress. But I beg you to remember in particular one tolerably constant diagnostic symptom of value: the patch of erythematous lupus on the hand, however it may differ in other respects from those upon the face, acknowledges its relation to the latter in its distinct outline. Only the palmar disk of our syphilitic patient had such a contour. All the other hands, whether affected with a dermatitis or an eczema, were singularly free from this distinctness of contour in their patches of disease. It is, in general, safe to say, never hastily decide that patch of cutaneous disease to be eczematous, where you can take a pen or pencil and distinctly outline the involved area at every point. Lastly, erythematous lupus usually involves one hand only.

There are a few other disorders found upon the hands which could scarcely be confounded with those we have here seen. In lichen ruber planus, the groups of glazed and umbilicated papules, found at the wrist chiefly, are the symptoms of a disorder rarely seen in this country. In herpes iris, or erythema multiforme, by whatever name you choose to call it, the mere fact of the concentric and regular arrangement of circlets of vesicles of different ages in a single patch, upon the back of the hand chiefly, would suggest the existence of a special disorder. This, though less rare than the affection last named, you will occasionally encounter. It is but a few weeks, since I was shown an exquisite example of this disorder upon the hands of a young woman, the patient of one of my colleagues.

Then there are those isolated, but often closely agglomerated, vesicles, or vesico-pustules, and even bullæ, excessively painful and often surrounded by an inflammatory halo, which are seen upon the lateral surfaces of the fingers, and, indeed, upon all parts of the hands, in those cachectic patients who have been sweating profusely. Fox, and Hutchinson, of London, and others, have given these lesions different names, "dysidrosis," "cheiro-pompholyx," etc., but their exact pathological history is not well understood.

The hands, too, especially on their dorsal surfaces, often exhibit patches of vitiligo. In such case the lesions are readily recognized by the entire absence in them of hyperæmic and exudative symptoms, and the manifest limitation of the anomaly, to the mode in which the pigment is distributed. The coloring matters of the skin are then merely absent in tolerably well-defined areas, and heaped up, as it were, about the borders of the decolorized disks, in chocolate to fawn-colored shades. Occasionally a species of irregular reticulum can be discovered over the backs, usually of both, of the hands, composed of blanched spaces surrounded by an irregular mesh of pigmented strizæ, the distinction thus presented to the eye being, in such cases, much more obvious during seasons of hot weather. At such times the effused sweat seems to be in part effective in what may be figuratively described as a sweeping away of the pigment material from certain definite whorls, around which it is accumulated in excess.



Lastly, we should not forget the frequent occurrence, in early life, of simple warts upon the hands; in middle life, when the patient is toiling in manual labor, of resulting palmar callosities, malignant pustules, dissecting wounds and erysipelas of the same organs; and, in advanced years, of the epitheliomata, which may occur usually upon the dorsum of one hand only, whose origin here can be frequently traced to an irritated wart or similar hypertrophy.

Let us note before we dismiss the subject, that the hands are commonly spared by psoriasis, whose plaques, however, in rare instances can be recognized upon the dorsal surfaces. Their occurrence upon the palms may be regarded as a pathological curiosity, and upon the palms only, as an expression of the disease to be received with great doubt and reserve. Tinea versicolor is never seen on the hands, though the other vegetable parasites may flourish there, and even involve the nails. These organs also are affected in many diseases involving other regions of the skin, as in lepra, pityriasis rubra, multiple sarcoma, and the exanthemata. In smallpox the pustular lesions are here, as a rule, much less numerous and well-developed than upon the face, and the resulting cicatrices are proportionately fewer and inconspicuous, often entirely absent when the face is deeply scarred.

Now the treatment of the hands, we have seen, is a very simple matter. Our syphilitic patient alone will receive internal treatment, the biniodide of mercury in union with the iodide of potassium, which we are accustomed to employ in the combination known as the *siròp de gihert*. His hands will be macerated at night in very hot water, and then well anointed with equal parts of Squibb's six per cent. mercurial oleate and vaseline, retained, during the night, in contact with the skin by drawing over the hands a pair of undyed leather gloves. All the other hands will get well if the cause of the disease in each be removed, and the organs are given sufficient rest. This is a matter of some importance. Never permit yourself to be pushed by a patient into the false position of attempting to "cure" the disease of his hands, with your drugs for the stomach and salves for the skin, while the sufferer is aggravating the trouble in the daytime by the accidents of his daily toil. If for the poor hard-worked seamstress, and the poor father of a large family, the latter is imperative, you can sympathize with their necessities, and aid them greatly, while you give them to understand that your method of treatment is not the best and most effective, but vastly inferior to another. In other words, tell them the whole truth, that the organs will take care of themselves if simply protected and disused.

The first thing to do under such circumstances is, for those which are acutely inflamed, to soak them well every night in a weak solution of borax or the bicarbonate of sodium, in water just as hot as can be comfortably tolerated, the hands being immersed for from ten to twenty minutes. This is usually grateful, alleviates the itching, and is not followed by the sharp reaction of cold water. Then they may be well smeared with a lotion composed of equal parts of olive oil and lime water, to which has been added a drachm of the bismuth subnitrate, and, when the itching is severe, also a drachm of dilute hydrocyanic acid. This makes a creamy preparation, usually well tolerated by the skin, which can be applied on soft bits of old muslin covered, if need be, with oiled silk or the Lister protective, to prevent evaporation. As the acuteness of the disease subsides, under the topical treatment, you may either protect their hands by the dusting powders, and for the financially impoverished, a package of "Oswego Gloss Starch" from the nearest grocer answers well; or you may select one of the many ointments useful in eczema, such as calomel, bismuth, zinc

oxide, or litharge, incorporated with vaseline or cold cream. Only in chronic forms of the disease of the hands will it be proper to use such stimulating topical medicaments as those compounded of tar, resorcine, gynocardic acid, and naphthol.

One of our patients was decidedly worse in consequence of having applied a poultice to the hand. The use of poultices in diseases of the skin is much more limited than in surgical and medical practice. They are properly limited to the cases where crusts or other pathological deposits are to be softened before removal, and to cases where the skin is to be softened before exit is given to pus, either within or below its tissues, as in furunculosis and carbuncle. For disorders of the skin proper, such as eczema, dermatitis venenata and medicamentosa, and similar affections, the weakening of the skin by the action of a poultice is in general to be deprecated.

But we must not lose sight of the fact we had in view, before discussing any method of treatment. Protect these hands in a state of disuse, and they will all speedily improve, even those of the syphilitic patient; while the others will finally exhibit a complete involution of their several diseases.

## ORIGINAL ARTICLES.

### ON THE USE OF THE ACTUAL CAUTERY (THE THERMO-CAUTERY OF PAQUELIN) IN THE TREATMENT OF CARBUNCLE.

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CONSIDERING the length of time that it has been recognized as a special surgical affection, the unmistakable character of its symptoms, and the numerous investigations that it has been the subject of, it is remarkable how diverse are the opinions, even to-day, held respecting the cause, the anatomical seat, and the safest and best treatment of carbuncle. Is it constitutional or local; does it depend upon injury, the entrance from without of micro-organisms, or the presence of morbid or irritant materials circulating in the blood; is it an evidence of, and consequent upon, diabetes; or may a condition of glycosuria be produced by it, to disappear before or at the time of its healing; is it the result of, or how far is it affected by, weather changes, mental disturbances, high living, or overwork and privation?

Is it primarily a dermatitis or a cellulitis; does it start in the sebaceous follicles, in the sweat glands, in the ordinary subdermal connective tissues, or in the *columnæ adiposæ* of Warren?

Interesting questions, all, but not to be considered at present. As respects treatment, there is as little unanimity of opinion. Shall reliance be had upon the internal administration of drugs; and, if so, shall they be tonics and stimulants, or supposed special eliminants, or recognized parasiticides, as iodine and the bichloride of mercury? If any local treatment is employed, shall it be simple poulticing or hot-water dressing, or stimulating applications, as turpentine or blisters; or shall incisions be made, that tension may be relieved and the separation of sloughs facilitated; or shall the whole tumor be cut away; or shall the cautery, actual or potential, be early and thoroughly applied?



That many of the less severe cases will, without much trouble, get well under simple treatment, every one knows; and at times even the more threatening ones will eventuate well. The largest carbuncle that I have ever seen, occupying the posterior half of the left thigh in its lower two-thirds, was recovered from in about five weeks, and with very little resulting impairment of the functional integrity of the limb, under the application of mixed castor-oil and turpentine. The long-time standard treatment by incisions, transverse or crucial, is known to occasion at times severe, even dangerous bleeding; and very often neither relieves the pain, arrests the spread of the inflammation, nor, by facilitating the separation of the sloughs, hastens the recovery. Subcutaneous incision is followed by no better result in many cases. The application of caustics (Vienna paste, chloride of zinc, etc.), which has been with some, particularly the French, surgeons a favorite, is objectionable on account of the pain that is caused, the excessive suppuration which may follow, and the considerable loss of substance which is often produced. The use of the actual cautery is not new; but only within a few years, since the introduction of the Paquelin instrument, have we had a convenient way of using high heat without the unpleasant accompaniments, not to say annoyances, of the old-time cautery irons.

As the result of my own observation, limited, it is true, but still sufficient from which to draw some conclusions, I am satisfied that by the early application of the thermo-cautery knife, or, much better, the hammer-head (if I may so term it, the *foyer en forme de champignon*, of Collin), the pain may be quickly, generally almost at once, relieved, and the progress of the inflammation arrested. The reported observations of others, as those of Verneuil and of Post, confirm me in my opinion. In the cases that I have treated in this way little or no suppuration has occurred, and the eschar has separated in due time, leaving a healthy granulating surface that has soon cicatrized. Even when the carbuncle has been fully formed, and pus has begun to discharge through the skin-openings, I have derived, I believe, much positive benefit from the thorough application of the cautery, thrust into and through the dead tissue; materially lessening the suppuration, stopping the extension of the disease, hastening repair, and securing a scar-deformity decidedly less than that after any other method of treatment.

Either a white-heat or a dull red may be employed; the use of the latter, of course, being much less likely to be attended with bleeding. In my own cases no troublesome hemorrhage has been produced by the application of the highly-heated cautery. The after-treatment has been very simple, either dry cotton or hot-water dressings being applied until after the separation of the eschar or the slough.

As every one will admit, the special danger in the severer cases of carbuncle lies either in the exhaustion consequent upon protracted suppuration occurring in an individual already debilitated, or the subject of grave organic disease, especially of

the kidney; or, as is more usual, in the great liability to the development of one or other form of blood-poisoning. There must, therefore, be great advantage in a method of treatment which will promote early separation of the dead tissue, will restrict the suppuration within comparatively narrow limits, and will—as Langenbeck has stated—best secure firm clots and prevent pyæmic accidents. Without presuming to go as far as Vallette has done, in declaring that for carbuncle the actual cautery is “an unfailing specific, more infallible than quinia in the treatment of intermittent fever;” and fully believing with Trelat, that “every exclusive method is bad in so far as it is exclusive,” and that “the treatment must vary according to the progress and form of the swelling, and also according to the general condition of the patient;” I cannot but think that in other than the milder cases the use of the thermo-cautery will yield better results, as respects time, suffering, and local damage, than any other method of treatment, therapeutic or operative. As in the first day or two it is often impossible to determine whether the carbuncle is or is not going to run a mild course, as cauterization may abort the disease, and as it is a procedure not specially severe, and not in and of itself dangerous, one certainly would be justified in its early adoption in any case.

#### EXCISION OF ULNA FOR OSTEOMYELITIS, CONSECUTIVE TO AMPUTATION FOR GUNSHOT WOUND.

BY WILLIAM A. BYRD, M.D.,  
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OSTEOMYELITIS of a violent type is one of the most unfortunate circumstances that may complicate the progress of a case after amputation. Many lives have been sacrificed by temporizing; the surgeon hoping that the bone may necrose completely and be thrown off, instead of amputating above the next joint. It would be useless for me to go into the consideration of this matter upon this occasion, and any one interested in the subject will find it very ably elucidated by Prof. Chas. MacNamara in his *Lectures on Diseases of the Bones and Joints*, 2d ed. I take it that Prof. John Ashhurst, Jr., agrees in the main with Mr. MacNamara, from the statement he makes regarding this condition in his article upon amputation in the *International Encyclopedia of Surgery*, vol. 1. pp. 604, 605. Other authors that I have consulted do not seem to be as well settled in their convictions, as the matter is written about very indefinitely.

When acute osteomyelitis sets in after an amputation of the forearm, a proper conservatism would require that an exsection should be performed, taking away the whole of the diseased bone, which is the focus of infection. That the radius should be so treated I suppose none would gainsay; but the possibility of having a stiff enough articulation between the ends of the radius and humerus, or there being no reproduction of bone from the ulnar periosteum, so as to procure an artificial joint, therefore allowing the end of radius to hang off loose from the end of the humerus, like the end-

stick of a flail, might deter some surgeons from making an excision of the ulna. But should such an untoward result ensue, the radius could be removed at the elbow-joint, after a sufficient time had elapsed to prove that it would remain useless; or, possibly, be in the way. Such an operation would be one of comparatively little danger, as only soft tissues would be involved in the incision, and the patient would receive the benefit of the doubt.

The following case will illustrate my meaning: October 18, 1881, George Mullican, a robust countryman, aged 26, while out hunting discharged one barrel of his gun while dragging it after him in the brush. The charge of duckshot passed through the left wrist and lower arm, leaving the hand attached to the arm by only a few mangled tendons, and an anterior and posterior strip of skin. He walked some four miles to a railroad station, and came to the city on the first train, having tied a handkerchief above the wound to prevent hemorrhage. I saw him about four hours after the receipt of the injury, and amputated the arm, with the assistance of Dr. Geo. W. Connell, at St. Mary's Hospital, at the junction of the lower and middle thirds. The arteries were twisted and the flaps brought together with catgut sutures. The wound healed almost entirely by first intention, there being a very small spot at one corner that granulated. He progressed so nicely that I let him go home, ten miles in the country, on the 31st of the month. I met him almost every day for awhile, as he would come into the city in the morning and return home in the evening.

The night of November 21st he went to a dance, and remained up nearly the whole night. The next morning, feeling very badly, he concluded to come into the city and see me. He went to the railroad switch, where there was no depot, but where the trains stopped for passengers. The day was very cold and rainy, and the train was an hour and a half behind time, so by the time the train arrived he was thoroughly wet and chilled. When he got to my house he had a high fever, and the arm was quite painful. He was sent to St. Mary's Hospital. When I called to see him in the evening the right lung was hepatized, and he was raising rusty-colored sputa with the cough he had. Rigors ensued, with copious sweatings. The stump became greatly swollen and suppurated freely. Shreds of connective tissue came away, and the cicatrix at the end of the stump gave away, leaving the ends of the radius and ulna exposed. The ulna was discolored, eroded, and the discharges from it were quite offensive. A sinus opened just to the inner side of the coronoid process. Appetite was gone, tongue was dry, and there was a pinched appearance of the face, with occasional delirium. Having just completed the reading of Mr. MacNamara's most excellent book, I lost no time in putting his advice to the test. November 29th, after carefully examining both bones, and finding the radius perfectly sound, I decided upon removing the whole of the ulna, which was done with the efficient aid of Dr. G. W. Connell. The bone was so eroded that it was almost divided, and had lost

at least half its original weight. All this destruction of bone in one week!

The delirium left him immediately after the operation; the dullness of the lung gradually passed away; but the rigors still continued, though much less severe than before. There remained hepatic enlargement and pain, with a continuation of the sweating. Thinking that I detected deep fluctuation in the liver, just at the lower edge of the ribs, I passed an aspirator needle three inches deep into its substance, at about the outer end of the eleventh rib, December 7th, when about a drachm of sero-purulent fluid was obtained—nothing more. The next day his side was free of pain, and after this the hepatic enlargement gradually disappeared without further pain.

December 24th he left the hospital, still having some night-sweats, and greatly reduced in flesh. The wound in the arm was healed, and the joint stiff. My advice was to move the joint as much as possible, as soon as the tenderness would permit. He gradually recovered his health, and the joint became more and more useful. There does not seem to be any reproduction of the ulna, but in its place there is fibrous tissue that answers the place of the bone very well. This tissue may eventually



Diagram showing the extent of flexion and extension possessed by the arm.

ossify. He can hold a fork in the flexure of his elbow when carving his food; uses the radius to hold his lines when driving horses; and, in fact, finds the arm very much more useful than it would have been had it been amputated above the condyles of the humerus, or even at the joint. The accompanying figure, from a photograph taken a few days since, shows the result of the operation.

#### THE REDUCTION OF CANE-SUGAR BY HYDRO-CHLORIC ACID AND BY GASTRIC JUICE.

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WHILE conducting a series of experiments having for their object the behavior of intestinal juice, *i. e.*,

glycerine extract of intestinal mucous membrane, in fluids of various reactions, I noticed that in all cases where HCl was used there was a decided action on cane-sugar. Even in juices, which were almost inert as regards cane-sugar in neutral or alkaline solutions, I always had a decided grape-sugar reaction in fluids acidified with HCl, and the greater the acidity the better marked was the reaction. The reducing sugar resulting from the digestion of cane-sugar is called grape-sugar mainly because it reduces copper salts in alkaline solutions.

From later researches carried on by a number of authors it is somewhat doubtful whether the sugar formed in digestion from starchy matters or cane-sugar, is grape-sugar or another sugar corresponding with the former merely in several of its reactions. Indeed, Claude Bernard, who first pointed out the power of intestinal juice to convert cane-sugar, stated that the resulting substance was a mixture of dextrose or grape-sugar and levulose. The term grape-sugar is therefore used provisionally only in this paper. This constant production of grape-sugar in acid solutions of course led to the proposition that HCl was the active agent.

It is well known that a solution of several per cent. HCl will reduce cane-sugar at the boiling temperature, but as to its effect in much greater dilution, and at a lower temperature (40° Cent.), I could find no statements in the literature at my command, and hence proceeded to investigate for myself, the process being in brief as follows: Cane-sugar solution was added to HCl, of such concentration that the quantity of sugar solution added would bring out the desired per cent. of acid in the resulting mixture. .5 gr. of cane-sugar in 20 c.c. of mixture was the usual proportion, being equal to 2.5 per cent. of cane-sugar, or 2.62+ per cent. of grape-sugar in case it should all be converted into this substance. The per cent. of HCl in the different mixtures was varied as stated in the table below. Tubes charged with such solutions were then placed in the digester, kept at a temperature of 40°-41° Cent., and their contents examined at given times, as seen in the table.

Percentage of Grape Sugar Found.

HCl per cent.	.15 per cent.		.2 per cent.		.3 per cent.		.5 per cent.		.6 per cent.		.75 per cent.		Time.
	Acid.	Juice.	Acid.	Juice.	Acid.	Juice.	Acid.	Juice.	Acid.	Juice.	Acid.	Juice.	
Sugar in per cent.	.35	.31	.67	.67	1.11	1.15	2.08	2.06	2.41	2.46	2.44	2.38	
	.73	.86	1.43	1.50	1.67	1.72	2.18	2.25	2.41	2.46	2.44	2.50	
	1.07	1.11	1.79	1.73	2.22	2.18	2.44	2.44	2.44	2.50	2.60	2.60	5 hours.

The quantitative analyses were made by Prof. C. C. Howard with painstaking accuracy, and can be thoroughly relied upon. The Fehling method was the one used for these determinations.

HCl in even greater dilution than any indicated in the table will reduce cane-sugar under the same conditions. As shown by simply qualitative tests so little as .005 per cent. of HCl will give an appreciable quantity of grape sugar in about two hours.

Seeing from these experiments with what facility cane-sugar is reduced at the body temperature by

very dilute acid, it suggested itself that the gastric juice, containing as it does free HCl, would have a similar effect unless indeed its pepsin or some other constituent would materially alter the process.

Another set of experiments was made, comparing pure acid solutions with artificial gastric juice (glycerine extract of stomach) of the same titre. From these it appears that the pepsin has no effect whatever, the quantities of grape sugar obtained in parallel cases being sufficiently close to be accounted for by the unavoidable errors of analysis.

Natural gastric juice, as obtained from the dog through a gastric fistula, has a speedy reducing action on cane-sugar, as I have already stated in a paper read before the Ohio State Medical Society. The inference is that the action here as in the artificial juice is due to the free acid. Certainly, the more marked the acidity, the more speedily is the grape-sugar to be found. Occasionally a juice is obtained very slightly acid, especially after the animal has been used for several days in succession and the stomach considerably irritated, which does not reduce cane-sugar, nor does it however have any action on fibrin. The mucus which sometimes flows from the fistula in abundance at the beginning, and which is said to slowly reduce cane-sugar (Foster), can be easily separated from the pure juice by filtration.

Quantitative experiments, whether it is the acid in the natural juice, too, to which the reduction must be ascribed, and whether any modifying influences come into play here, are now in progress and will be communicated in due time.

I am led to make this preliminary statement from the fact that Leube (*Virch. Arch.*) has recently, but after the preparation of my paper referred to above, announced that the human gastric juice also reduces cane-sugar.

The commercial cane-sugar I find is totally unfit for these experiments, as all obtainable samples already contain a notable quantity of grape-sugar; crystallized sugar in the shape of rock candy, however, can readily be obtained free from such admixture.

## REMITTENT FEVER IN THE SOUTH.

BY FAIRFAX IRWIN, M.D.,

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REMITTENT fever, or as it is popularly called on the Cape Fear, "river fever," is so common, and aside from its dangerous character, so expensive to ship-masters and owners that a few remarks on its character and treatment will not seem out of place, especially at this its chosen season. This article is based on the results obtained from the treatment of ninety cases of remittent fever during the past



eighteen months, all of which have recovered with an average duration of treatment of about nine days per man.

These cases were all treated in the Marine Hospital in Wilmington, N. C., and were, as a result, in a very favorable situation for observation. To the treatment, followed with little variation in all cases, the favorable result is attributed. That too much is not claimed will be readily allowed by any who are acquainted with the character of the malarial fever in this region, and especially when it is remembered that this disease is clinically the same as the bilious fever of thirty or forty years ago, which was itself so fatal.

The river fever is seen but in isolated cases before August, and from that time increases in virulence until the kindly hand of frost is laid upon it.

The most severe cases are seen among the sailors, especially those unacclimated, and is directly traceable to exposure at night to the poisonous exhalations from the rice fields along the river. The sailors sleeping upon the vessel-decks on warm nights are soon attacked, while the captains sleeping ashore usually escape entirely. Seamen from foreign vessels fall an easy prey, and give the largest percentage of malignant cases.

It is not to be forgotten, however, that sailors in addition to exposure are usually filthy in their habits, reckless and dissipated to a degree. Before passing to a short sketch of the natural history of this fever, it may be well to refer to a common idea held by seafaring men, that salt water "brings out the fever," a vessel after remaining for ten days or two weeks in the Cape Fear River usually drops down to Smithville at its mouth, to complete loading, and here frequently, after having been healthy all of the time spent above, the crew succumb almost suddenly to fever, hence the notion of salt water "driving it out." I believe this is nothing more than a coincidence, the outbreak of the disease after its regular period of incubation. Sailors have died at sea after leaving Wilmington, of the fever, though healthy on departure and with such malignant symptoms as to cause masters to report them as cases of yellow fever.

Remittent fever as I have seen it here, after an incubation of from ten days to two weeks breaks out quite suddenly and with alarming symptoms from the first. Perhaps in some cases a certain lassitude and weakness for a few days may precede, but as a rule the onset is sudden.

Contrary to the statement in most works on the subject, there is no initial chill; this did not occur in any of the ninety cases treated. Many men were brought into the hospital insensible, having been taken sick during the day.

The prominent symptoms were a dull, stolid countenance; weary, slouching gait; acute lancinating pains in the head and back, dull pains in the limbs, tenderness on pressure over the region of the stomach with great irritability of that organ; a characteristic tongue, large, flabby, showing indentations of the teeth, and thickly coated with bluish-white fur, rarely dry except in protracted cases, and often so large as apparently to fill the mouth.

The coating was often absent, but the bluish-white tint was invariably present.

The full rapid pulse, throbbing carotids, and moist surface showed the excited circulation. The sweats were in most cases as copious and as debilitating as in phthisis. The temperature ranged from 100° to 105° (38° to 40.4° C.) on the first evening, the average being 104° (40° C.)

There was a marked tendency to congestion of various organs, especially the lungs, but an implication of the liver to any appreciable extent was not observed; the yellow hue of the skin so often spoken of in books was not seen. Albumen was not discovered in the urine in any case. Delirium was rarely present, severe cases were more apt to become comatose. The irritation of the stomach was frequently most severe and difficult to manage, everything being rejected and passing on to the vomiting of pure bile. There was no eruption.

There is little danger of a mistake in diagnosis: the season of the year, the sudden seizure, the steel-colored tongue, acute pains in the head and back, and distinctly remittent range of temperature are characteristic.

There was rarely more than one exacerbation, owing, it is believed, to the large doses of quinia used. When a second exacerbation followed, it was always found to be due to an insufficient use of quinia. In the whole number of cases treated there was little variation of symptoms, but a few interesting exceptions may be mentioned.

Epistaxis was somewhat common and one case required plugging of the nares to prevent exhaustion from loss of blood. Hemorrhages from the bowels was present in a case which lasted two weeks; there were no other symptoms of typhoid fever, however. One case so strongly simulated cerebro-spinal fever as to leave the diagnosis in doubt for a few days; there was well marked opisthotonos, but recovery followed in due course.

A case in private practice seen in consultation with Dr. Geo. G. Thomas, of Wilmington, had the Cheyne-Stokes' breathing perfectly, and presented the appearance of approaching dissolution. Large doses of quinia were being given but the disease had advanced so far before advice was asked for that it seemed as if the nervous system would be overwhelmed by the poison before the remedy had time to act. A blister was applied to the back of the neck and atropia sulphate (0.0010 gramme) given every three hours, with good effect, and recovery followed. Atropia was given to counteract the slow spasmodic breathing; the *besoin de respirer* being almost absent, as in opium poisoning.

The treatment used in the ninety cases to which this paper chiefly refers was based on the principle that remittent fever is caused by a poison now known as malaria, which is present in almost overwhelming degree, and to which quinia is a direct antidote if used in large doses.

Cases showing the usual evening temperature of 40° C., and upward were given from 30 to 45 grains (2 to 3 grammes) of quinia sulphate, usually in solution with dilute sulphuric acid, and largely diluted with ice water. As the stomach in many cases was

so irritable as to reject this really nauseous dose, the quinia was then given in pills freshly made with glycerine; when these were rejected, as was often the case, the drug was administered hypodermically, the dose in this case being from 10 to 15 grains (0.666 to 1 gramme). The solution for hypodermic use was made with citric acid, and although many times used, no abscess ensued in any case.

This large dose almost invariably reduced the temperature from one to three degrees by morning, the quinia was then given in doses of 5 grains (0.333 gramme) thrice daily, and the large dose again repeated at night if the temperature rose. This method, with a few exceptions, cut short the fever in from three to five days, as the average duration of nine days for the whole number of cases will show. Some, especially where there was an existing organic disease, were more rebellious, and required large quantities of quinia before convalescence was established.

As much as 465 grains (30 grammes) of quinia were given in eight days in two different cases, and no ill effects were observed; in fact in no case did quinia cause any disturbance beyond deafness which soon passed away under cessation of the drug and small doses of hydrobromic acid. Dimness of vision was never complained of.

If the bowels were inactive, an enema was given at once, but no preparatory treatment was ever used. As the skin and kidneys were active, opium or diaphoretics were not called for. To moderate the heart's action fluid extract of aconite-root in one drop doses every four hours was given in most all cases; this, with ice compresses to the head, was about all the treatment.

The irritable stomach was best controlled by creasote or vin. ipecac. (5 minims) 0.333 cc. every two or three hours.

Rigid milk diet was given and no stimulants used. It is desired to insist upon the needlessness of the almost universal custom of preparing the system for the action of quinia, much valuable time is lost in an unnecessary procedure and it is thought that opium is positively contraindicated by the symptoms.

In conclusion, the fact should not be lost sight of that remittent fever is eminently a disease to be prevented. While vessels are in the river, the crews should be required to sleep ashore. Captains should be furnished with clinical thermometers with instructions for their use, and on the first indication of fever, a dose of at least 30 grains (2 grammes) of quinia should be given.

The total number of cases observed during eighteen months was ninety, total number of days treatment four hundred and forty, average per patient nine and one-third days.

## HOSPITAL NOTES.

### VIENNA GENERAL HOSPITAL.

(Service of PROF. CARL BRAUN.)

#### CÆSAREAN SECTION WITH SUPRAVAGINAL AMPUTATION OF THE VAGINAL PORTION BY PORRO'S METHOD.

(Specially reported for THE MEDICAL NEWS.)

THE fall semester of the Vienna Medical School has commenced in all departments with unusual brilliancy.

Upon the second day of the new term, October 17th, Prof. Carl Braun performed a Cæsarean section, Porro's method, before his class, upon the person of a dwarf.

The patient, a native of Austria, thirty-six years old, married, was received into the wards during September in her *eleventh pregnancy*. The history of the case, as collected from the records of the three obstetrical clinics of the General Hospital, is briefly as follows:

The members of patient's family, with exception of herself, were perfectly healthy; three sisters, who are now living in the country, are in a normal condition.

In 1866, the patient came to Vienna to live; in 1869 she became pregnant, and was delivered, in the eighth lunar month, of a child, which is living to-day; instrumental aid was required in this labor.

She married in 1871, and became pregnant in 1872; the second pregnancy resulted in an abortion in the sixth month, during convalescence from an attack of typhus. Since 1873 she has suffered more or less constantly from "gout" ("gicht"), and has aborted in each of her succeeding pregnancies, until the present one, before the sixth month.

The patient was a dwarf, of delicate frame, was unable to walk, and could not move her upper extremities without pain; she was greatly emaciated; the bones were soft, somewhat pliable, and very sensitive, although she did not present to view as high a degree of *osteo-malacia* as one frequently observes in Austria.

When lying flat upon her back she was comfortable. A remarkable degree of intelligence was evinced throughout her stay in the hospital.

She stated that her last menstruation occurred about January 25th. Examination by abdominal palpation confirmed her statement, revealing pregnancy in the ninth lunar month, head presentation; combined external and vaginal exploration revealed an osteomalacic pelvis possessing a high degree of asymmetrical contraction, constituting a "three-cornered pointed heart figure" (*dreiwinkelig spitze herzfigur*), classified by Braun under the category of "more rarely occurring contracted pelvis."

The right sacro-cotyloid diameter or microchord of Ritgen measured 4 cm.; the left microchord measured 3.5 cm.; the normal length of each microchord is 8 cm. The horizontal branches of the pubes were prolonged forwards into a beak-like process, and measured between their bases 3 cm.; the transverse diameter of the pelvic entrance, measured through the promontory, was between 9 and 10 cm. The *conjugata vera* measured 8.5 cm.

The patient was at once isolated, given special diet, and preparations were made for Cæsarean section.

About 6 o'clock P. M., October 17th, the bag of waters ruptured, and active labor pains speedily followed.

Prof. Braun was summoned, and three hours later, assisted by Drs. Massari, Felsenreich, and Pritzel, performed Porro's supravaginal amputation of the vaginal portion, with Müller's modification. An interval of 30 seconds elapsed between the primary incision into the uterus and the removal of child and placenta.

The child cried lustily upon emerging from the uterus, proved to be a male, with a weight of 2800 grammes, and a length of 49 cm. The child, when last heard from in the Foundling Hospital, much to its father's disgust, was in a very vigorous, thriving condition.

After the pedicle had been carefully ligated, beneath the chain of Billroth's écraseur, this instrument was removed and replaced by the same surgeon's ovariectomy clamp. The stump was then thoroughly cauterized with Paquelin's thermo-cautery and the ovariectomy clamp was removed. A second set of ligatures were applied through the first system, in such a manner as to secure an approximation of the peritoneum of the

pedicle, upon all sides, over its raw surface. The pedicle was about to be returned to the abdominal cavity, when bleeding was noticed. The stump was again compressed by the ovariectomy clamp, both sets of ligatures removed, and reapplied.

After waiting some time, and noticing no recurrence of the hemorrhage, the *toilette* of the peritoneum was quickly performed, the pedicle returned to the abdominal cavity, and the abdominal incision approximated by the usual deep sutures of the lead-plated silver wire, and superficial silk stitches.

The woman reacted after the operation fully, and very little evidence of shock was perceptible.

The first day, after the operation, passed without moment; temperature being  $37^{\circ}\text{C}$ .; upon the second day, the patient commenced to vomit, and temperature rose to  $38^{\circ}\text{C}$ .; upon the third day, morning temperature was  $39^{\circ}\text{C}$ ., evening temperature,  $37^{\circ}\text{C}$ .; upon the fourth day, towards evening, the woman died, with temperature of  $38.6^{\circ}\text{C}$ ., and with all the symptoms of acute septic peritonitis.

The autopsy, conducted next morning, by Prof. Kundrat, revealed the usual lesions of acute septic peritonitis. In the cul-de-sac of Douglas, two or three ounces of bloody pus were visible. The plexus pampiniformis venosus, upon the left side, was filled with thrombi, and distended to the size of a large thumb.

Upon the right side of the stump, several ligatures had become loose, and hemorrhage into the cul-de-sac of Douglas had evidently occurred from the right plexus pampiniformis venosus, giving origin, doubtless, to the septic peritonitis.

Prof. Braun, in his remarks to the class, in the light of the autopsy, stated very emphatically that he would never again treat the pedicle of a pregnant uterus by the intra-peritoneal method. He was equally positive in asserting that the pedicle of uteri, amputated on account of fibroid tumors, should be treated by extra-peritoneal fixation. Prof. Braun quoted his brother, Prof. Gustav Braun, as fully concurring with himself upon the subject. The latter lost a very promising case after the same operation, last spring, from secondary hemorrhage.

Prof. Carl Braun has performed Porro's operation nine times. In eight cases the pedicles were treated by the extra-peritoneal method, and five recoveries were recorded. These five cases are living now in Vienna, and are exhibited annually at the clinic. The ligatures in Prof. Braun's last case were of strong silk, prepared antiseptically, and were most carefully applied.

## MEDICAL PROGRESS.

**NEW OPERATION FOR SALIVARY FISTULA.**—At a meeting of the Cincinnati Academy of Medicine held on October 30th, DR. J. L. KROUSE reported a case of salivary fistula, stating that it was of interest on account of the operation employed being different from that usually mentioned in text-books, and on account of its favorable result.

The patient, a girl of five years, four months ago injured herself by falling upon a sharp piece of wood, which entered her cheek. The greater part of the foreign body was removed at the time of injury; but subsequently several smaller pieces came away. The wound discharged all the time, and not seeming to get any better, the mother brought the patient to the clinic of the Medical College of Ohio. Here the speaker saw the patient for the first time. She presented on the left cheek, midway between the angle of the mouth and the concha of the ear, a linear cicatrix, vertical in direction, of  $1\frac{1}{2}$  inches in length. At the upper border of the same, there was a large vesicle filled with turbid

fluid. This, the mother said, would burst every now and then, discharging the watery contents over the cheek. As long as there was a free outlet to the secretions, the patient complained of no disagreeable symptom; but when the opening closed, then pain as well as swelling of the parotid region supervened.

On August 4th, that is three months after the receipt of injury, he operated by passing a silver wire armed with two straight needles through the external opening into the buccal cavity. The free ends of the wire were then twisted in the mouth and the external wound closed.

The object of the wire was to maintain an opening between the injured duct and the buccal cavity; it was allowed to remain there until the external wound had closed.

On September 5th, thirty-two days after the operation, the wire was removed. The recovery was perfect. The last time that the patient was seen was on October 24th, seven weeks after removal of wire. At that time the wound was still closed.—*Cincinnati Lancet and Clinic*, November 18, 1882.

[This operation is essentially the same as that described by Richelot. See THE MEDICAL NEWS, Aug. 12, p. 180. The elastic ligature is to be preferred on account of its greater rapidity of action. The whole method is however not new, being described in the French classics as the method of Deguise.—ED.]

**ADVERSE OPINIONS ON TRANSFUSION.**—PROF. VERNEUIL recently objected to the operation as a dangerous one, from which he had never seen any ultimate good derived, while the advantages which are said to attend its employment are obtainable by the hypodermic injection of ether. Recently, also, at the German Congress at Eisenach, Prof. König, of Göttingen, observed (*Berliner klin. Woch.*, October 2) that formerly he was a warm advocate of transfusion, but that he has come lately, like the majority of living surgeons, to think little of it. He has only quite exceptionally, and perhaps never, seen a favorable result follow its use, while from the injection of ether good effects are sometimes obtained. He therefore warns us not again to fall into the former prevalent transfusion-deception (*Transfusionschwindel*). Prof. Schede stated that he was of much the same way of thinking as König, and now resorted to transfusion much seldomer than formerly.—*Med. Times and Gaz.*, Nov. 11, 1882.

**A NEW TREATMENT OF DIABETES.**—ADAMKIEWICZ believes that protein, the fundamental substance of the organism, may be regarded as being composed of sugar and ammonia, less some elements of water and oxygen. Consequently, if one could fix the excess of sugar present in diabetics by means of ammonia, we would have a chemical physiological treatment.

In his first series of experiments made on healthy men at the Berlin Charité, he arrived at the following conclusions: The chlorhydrate of ammonium is not decomposed in the intestinal tube of healthy men. The greater part of the ammonia absorbed with the chlorhydrate, disappears in the healthy body and probably appears in the urine in the form of albumen. The chlorhydrate of ammonium acts in the healthy body in about the same way as the chloride of sodium: it dehydrates the tissues and favors the decomposition of albumen. The decomposition of albumen and the excretion of albumen do not advance in parallel lines.

In his second series of experiments made on diabetics, he found that the ammonia disappeared rapidly, and that this assimilation coincided with a disappearance of sugar, and in slight cases the excretion of sugar might be entirely suspended. When the sugar does not disappear, the ammonia absorbed into the



system of the diabetic neither increases the quantity of water or urea; while when the sugar is absent the excretion of water is greatly augmented, proving that part of the ammonia is transformed into urea, and as such eliminated.—*Rev. de Thérapeutique*, November 1, 1882.

**THE RELATION OF CHOREA TO RHEUMATISM.**—MR. EDWIN RICKARDS read a paper before the Section of Medicine at the last meeting of the British Medical Association, whose purport was to support the view that chorea is a functional disease of the brain. From observation of a large number of cases, of many of which he has records, he has been led to believe that chorea occurs exclusively in individuals of an excitable nervous temperament, and at a time of life when the mind is least stable; that it may arise solely from excessive nervousness, which is frequently brought to chorea-point by fright, or some condition calculated to produce nervous debility. The fact, that mental disturbance is a potential cause of chorea, is, to his mind, presumptive evidence that it is the constant cause. In three of his cases, choreic movements followed the occasion of excitement within twenty-four hours. Now, if organic changes were brought about in so short a time, it is reasonable to suppose that, in protracted cases, terminating fatally, constant grave structural alterations would be found. Such, however, in his experience, is not the case. The proposition, that chorea is caused by mental disturbance, is supported by the fact, that the movements are to a variable extent under the control of the will; and when the mind is at rest, as in sleep, cease. The shifting, too, of the movements, seems to contraindicate any fixed lesion. It might be urged, Why does not fright more frequently cause chorea? To this objection, he would reply, that an attack of chorea from fright is determined by the nature of the terrifying agent, and the mental constitution of the individual. A trivial incident may seriously impress a nervous child, while a child who is not of a nervous temperament might not be shocked by a far more formidable occurrence.

And, now, as to the connection between chorea and rheumatism. The causal relationship between these two diseases must, at present be purely speculative, as the etiology of rheumatism is as yet undetermined. He is inclined to think that we must look to the nervous system for the primary cause of that disease. It seems to him probable that functional nervous disorder may lead to blood changes, which give rise to the symptoms indicative of rheumatism; and, if this were so, we should have a common cause for the two diseases. He has been much impressed by observing what nervous temperaments rheumatic patients possess—how great is the nervous debility during and after an attack; it is out of all proportion to what might be accounted for by the pain they suffer, and the *regimen* they undergo. His experience, up to the present time, has led him to the conclusion, that valvular disease of the heart is associated with chorea only through rheumatism. Four, and only four, chorea cases have been admitted into the hospital under him without heart-disease, and discharged from it with damaged valves. In these four cases, the endocarditis was accompanied by well-marked symptoms of acute rheumatism. In no one instance has he seen valvulitis develop in a choretic patient unconnected with rheumatism.—*British Medical Journal*, November 11, 1882.

**PRECAUTIONS TO BE TAKEN AS REGARDS TYPHOID FEVER.**—The Hygienic Council of the French Académie de Médecine have drawn up the following instructions to be observed when the presence of typhoid fever is recognized.

1. *Isolation.*—The patient should be isolated as far as possible from the other inhabitants of the house; if complete isolation is not possible, the patient should be taken to a hospital. If the patient remains in his home, only those persons who minister to his wants should have access to his chamber, while all children should be rigidly excluded. Nurses should wash in carbolized water, one per cent.

2. *Aeration of the Chamber.*—A room should be selected which can be readily aired. The hangings, curtains, and carpets should be removed, and the bed placed in the centre of the room.

3. *Disinfection of the Evacuations.*—All the ejecta of the patient, before being thrown out, should be thoroughly disinfected with a solution of chloride of zinc, 20 per cent. The privies into which the evacuations are thrown should also be flushed with this solution.

4. *Disinfection of Clothing.*—All the patient's body and bed-clothing before being removed from the room should be plunged into a solution of carbolic acid, 5 per cent., and then immediately washed.

5. *Disinfection of the Room.*—After the death or cure of the patient, charcoal should be burnt in the room with sublimed sulphur, and the chamber should then be closed for twenty-four hours. The chamber should then be washed with carbolized water, and not re-occupied until it has been freely aired for at least a week.—*Gaz. Hebdomadaire*, November 3, 1882.

**THE DIAGNOSIS OF SYPHILIDES.**—The diagnosis of syphilides is not at all times an easy matter, and any contribution to the literature of the subject will always be acceptable. DR. MAURIAC, Physician to the Hôpital du Midi, the well-known hospital for venereal affections in the male, delivered a very interesting lecture on the subject which may be summarized as follows: In giving a description of the topography of syphilides, Dr. Mauriac observed that their distribution on the different regions of the body presents certain peculiarities which are not found in other affections of the skin. Erythematous syphilide is found principally on the trunk and flanks, on the inner parts of the limbs, and on the flexor more than on the exterior aspect. The papular form has its seat of predilection on the face, the alæ of the nose, and on the forehead at the roots of the hair, the upper part of the neck, the trunk, and on the limbs in all directions. The scaly forms, with all their varieties, invade principally the palms of the hands and the soles of the feet. Pustular syphilides, superficial or impetiginous, affect the scalp, the beard, and, in general, the regions covered with hair. Ecthyma and rupia attack by preference the limbs, principally the lower limbs. As for tubercular eruptions, they are disseminated all over the body. Thus, it may be seen that syphilitic eruptions may affect the entire cutaneous covering of the body. There are, however, some parts of it which would seem to form exceptions to this rule, such as, for instance, the clavicular and sternal regions, where simple and parasitic eruptions are so common. The same may be said of the back of the hand, and this remark is particularly applicable to the exanthemata. Papulo-squamous eruptions are never seen on the limbs on the extensor surface, at least systematically, as is the case with one of the most common and most typical of non-syphilitic eruptions, psoriasis. The natural orifices, the commissures of the lips, isthmus of the fauces, orifices of the nostrils, the vulva, and anus, are the seat of predilection of the earlier syphilitic eruptions, and, among others, mucous patches are there particularly noticed. The circular forms of simple erythema may be found on all parts of the body; whereas the same forms of erythematopapulous syphilides affect

by preference the chin, the cheeks, forehead, the neighborhood of the anterior and internal parts of the limbs, and the buttocks. The syphilides appearing later and affecting the tissues deeply are generally situated on the nose, lips, scalp, the sternal and clavicular regions, the buttocks, and more frequently on the legs near the joints than on the thighs.—*Lancet*, November 11, 1882.

**TRISMUS OF CEREBRAL ORIGIN.**—PROF. LÉPINE reports the case of a woman who died of cerebral apoplexy, who as the sole convulsive symptom had persistent trismus from the onset to the termination of the disease. At the autopsy there was found a small hemorrhagic foyer in the gray matter of the insula and at the foot of the ascending frontal convolution. This is the point whose excitation in monkeys causes movements of the jaws.—*Rev. de Méd.*, October 15, 1882.

**CASE OF CARCINOMA OF THE STOMACH WITH PROGRESSIVE ANEMIA.**—The following case occurred under the care of DR. BARLOW, in University College Hospital, London: Eliza H., aged fifty, was admitted on August 4, 1880. She sought relief for vomiting and loss of flesh. There was no hereditary history of cancer. The patient had enjoyed fairly good health, except for occasional "bilious" attacks, till nine months previous to admission, when she first began to lose her appetite and suffer with sickness, especially after food. From this time till the present date she had rapidly got worse, and her friends had noticed the great wasting and peculiar sallowness of her complexion. She had not long since vomited black matter, and her stools she had noticed were at times black.

*Condition of Patient when first seen.*—Sallow, cachectic complexion; great emaciation; the skin lying in loose folds all over the body. Very marked anemia shown by the lips, conjunctivæ, and finger-nails. The superficial veins were not unduly distended. She had fairly good teeth and could masticate her food well, and there was no difficulty in swallowing. Though troubled with frequent vomiting, she complained of no pain, nor was there any tenderness over the abdomen on palpation; but a small hard tumor about the size of a pigeon's egg could be felt between the umbilicus and ensiform cartilage. This tumor, which could be felt lying in front of the spine, with its long axis transverse, did not pulsate, and only caused slight pain on pressure. The lower border of the liver could not be felt, and there was an intestinal note obtained on percussion over the lower two inches of the hepatic region in the nipple line. The spleen was not enlarged. The lungs were fairly healthy, nor was there anything noticeable with the circulatory system beyond feeble heart-sounds with reduplication of the first, and a small, compressible, weak pulse. The genito-urinary system was normal, as far as could be ascertained by symptoms and the examination of the urine.

On August 17, the blood was examined microscopically. The corpuscles were irregular in shape, many were smaller than natural, and they were all very deficient in coloring matter. They had a great tendency to run together—not into *rouleaux*, but to form an irregular fused mass. The white corpuscles were not greatly increased, but the red were very much diminished. When enumerated by means of Dr. Gowers' hæmacytometer, they were found to be only 32 per cent.

The patient daily became weaker, and the corpuscles diminished in numbers; on August 27 they were only 30 per cent. The vomiting still continued, and the emaciation and anemia increased. On September 26 the proportion of red corpuscles was reduced to 26 per cent., and the hæmoglobin only 11 per cent.

On September 27 she insisted on going home.

It was ascertained afterwards that the patient had been taken to Guy's Hospital, where her extreme anemia was noted as the marked feature of the case. She died in a very short time, and at the post-mortem examination, which was made by Dr. Peter Horrocks, a scirrhous of the pylorus was found without ulceration, and a small cancerous mass in the uterus.

*Note (by Dr. Barlow).*—The special features of this case was the intense pallor, so that but for the detection of the small mass, proved afterwards to be scirrhous of the pylorus, it might have been considered one of idiopathic anemia. It is important to bear in mind that there was no ulceration of the mucous membrane. The benefit derived, during the few days of its administration, from the pancreatized oatmeal-gruel recommended by Dr. William Roberts was most striking, and if only the patient had been willing to persevere with it she might have been saved a great deal of distress. In another similar case this preparation was used with the greatest advantage for over two months, during the early part of which there was very marked improvement in general nutrition; but the patient ultimately succumbed, with extensive deposits in other organs.—*Medical Times and Gazette*, November 11, 1882.

**PALPEBRAL CHANCRE.**—M. DELAPERSONNE (*Arch. d'Ophthal.*) of the ophthalmic clinic of the Hôtel Dieu, contributes a didactic article on the etiology, physical characters, symptoms, diagnosis, and treatment of chancre of the lid, with a brief analysis of two cases occurring in the service of M. Panas, Hôtel Dieu, in 1881, and of a case of M. Fournier. Some of the major observations that have from time to time been made by Galezowski, Panas, Ricord, Julien, Wecker, Desmarres, Mackenzie, and others, are referred to for the assistance of the bibliophile in this department of ophthalmic study. While the author does not deny the possibility of a simple chancre of the lid, he dwells upon its rarity, and emphasizes the only true support such diagnosis can have, viz., its physical characters, and the absence of secondary symptoms, even several months after the healing of the chancre. The etiological factors are here, as in the general sphere, hard to prove. Contagion can be attributed to the projection of saliva, or to fluids charged with syphilitic virus. Patients usually have a ciliary blepharitis antecedent to an ulcer or little ulcerations of the free border of the lid. Phenomena of inflammation are wanting. Patients complain of no pain, nor labor in lid-movements, nor of lachrymation, nor perhaps of deformity.

The physical characters of lid-chaucres are variable according to their seat. The most common habitat is the inferior lid, either the cutaneous surface or the free border. As a special adenopathic involvement, the preauricular ganglion takes precedence; after this, the ganglia at the angle of the jaw, and the submaxillary region. It is well known that the lymphatics of the lower lid and inner canthus find their way through the facial vein into the submaxillary and sterno-mastoid ganglia.

When situated at one of the commissures, the chancre takes the form of a fissural ulcer, precisely limited by the free border; on this account the diagnosis may be misconceived, the ulceration being like that following a chronic dacryocystitis. The induration and ganglionic engorgement will prevent the error.

Most rarely the chancre occupies the internal surface of the lid. Inflammatory symptoms are here the most intense, as conjunctivitis, corneal ulceration, and iritis.

After the cicatrization of the chancre, induration persists, even to the concealment of the lachrymal puncta, and their obliteration. Cicatricial bands may unite

the two folds of conjunctiva, and constitute a true symblepharon, with results even more serious than the chancre itself.

The diagnosis of lid- chancre is to be eliminated from that of a furuncle, chalazion, lupus, and cancer. The last has an irregular, slightly elevated border, field covered with papillæ, the skin cut out at the circumference, cauliflower in its appearance, and easily bleeds. An invaluable distinctive mark of cancer is the advanced age of the patient, and exceedingly slow march of the sore.

In order to attain the size of a chancre, an epithelioma of the lid sometimes occupies several years.

More difficult is the diagnosis of chancre from lupus, which it most resembles; but the less rapid advance of lupus, its occurrence in young persons, and the absence of lymphatic involvement usually suffice as characteristics of distinction. As a final test of diagnosis, the sore should be inoculated elsewhere on the patient, and the latter be kept under observation for several months.

Three cases are adduced in brief summary.—*Arch. of Dermatol.*, October, 1882.

**THE TRAUMATIC ORIGIN OF LOOSE BODIES IN JOINTS.**—In France, and Germany especially, the statement that in falls and blows upon the knee or other joint a portion of the normal articular cartilage and bone can be broken off and remain in the joint as a "loose body," has met with much opposition. In England this view has met with more general acceptance, and in modern special treatises and text-books no doubt is thrown upon it. On the one hand, cases are cited where persons with apparently perfectly healthy joints have after a fall or other severe local injury shown all the symptoms of "loose body;" and it has been found in some cases that corresponding more or less exactly with the outline of the loose body is a gap in the joint surface of the femur and tibia. On the other hand it is alleged that in these cases, although there may have been no previous signs of joint disease, there were really outgrowths from the articular cartilage that were broken off by the injury. In the gradual enlargement of these supposed outgrowths, the pressure upon the opposed joint surface has caused its absorption to an extent corresponding to the size of the outgrowths. This view will be held by most surgeons to be fanciful, and not to accord with the most simple and straightforward interpretation of the facts, and it has been rejected in this country. M. E. PONCET, of Ciuny, has approached this question from the histological point of view in a paper in the last number of the *Revue de Chirurgie*. Here he states that in capsular "arthrophyses" a gradual transition from cartilage through fibro-cartilage to true bone is not unfrequently met with, that there is sometimes calcification of the fibro-cartilage quite distinct from true bone, that in all specimens a hilus or remains of a pedicle are to be seen, while in none is there any capsule of newly formed fibrous tissue surrounding the loose body. In true traumatic "arthrophyses" he found, on the contrary, no hilus or sign of any pedicle, but the body was surrounded by a thin cortex of newly formed fibrous tissue, while a section showed that the line of separation of the bone and cartilage was sharp and abrupt, and without any intermediate zone of fibro-cartilage. The bony matter, too, was always placed to one side of the body, and was never completely surrounded by cartilage, but partially in immediate contact with the cortex of fibrous tissue which was found to be histologically continuous with the cell tissue in the cancelli. These observations certainly afford a further proof that "arthrophyses" may be produced by injury to previously perfectly healthy joints. M. Poncet advocates the removal of

"loose bodies" through a sufficiently free incision, but he disapproves of the subsequent use of a drainage-tube. Regarding the drainage-tube as solely intended to prevent the exudation from the wound passing into the joint, he endeavors to secure this object by suturing the synovial membrane with fine catgut, and closing the external wound in a similar manner. As M. Poncet mistakes the object for which the drainage-tube is used in such cases, his argument upon it is misleading. The tube is used to run off any excessive secretion from the synovial membrane that may be caused by the interference of the operation. M. Poncet's successful case only shows that in it this secretion of synovial fluid did not occur, and it would be rash in the extreme to argue from it to all cases of a like nature.—*Lancet*, November 11, 1882.

**ARTIFICIAL FEEDING OF INFANTS.**—DR. TARNIER recently read an interesting communication on the above subject before the Academy of Medicine of Paris. Although artificial feeding is considerably less common, we believe, in England and this country than in France, nevertheless there is far too much of it; and the high rate of mortality of infants under one year of age is unquestionably very largely due to the want of care in the choice and the employment of artificial foods during infancy.

Owing to the unsatisfactory nature of artificial feeding in France, the Academy placed the subject among its prize questions in the year 1878; but nothing very definite resulted from the sixteen essays which were sent in—partly on account of the uncertainty that prevails as to which is the best milk to use for the purpose. The milk of the ass, of the goat, and of the cow are the most employed. M. Tarnier contends that the milk of the ass most nearly resembles, chemically, that of woman, and has been used for a long time past, although not, indeed, extensively.

He urged on the Academy the need of initiating reform in this matter, and concluded his paper by formulating certain proposals, from which we select the following: 1. The life of young infants can only be preserved by maternal nursing. This must, therefore, be encouraged by every means in our power. 2. If the mother's milk is insufficient, it may be supplemented by other food. 3. Suckling by a wet-nurse is favorable for the nursing, but detrimental to the nurse's own child. 4. Artificial milk is much inferior to maternal milk: its use is always surrounded by considerable difficulties, however we may try to avoid them, and whatever milk we use. It should never be had recourse to except when essentially necessary. 5. To solve many of the difficulties inherent to the subject it would be well for the Academy to undertake an experimental inquiry. The subject is one of great interest, and as pressing in large cities in England as in Paris.—*Med. Times and Gaz.*, Nov. 11, 1882.

**IODIDE OF POTASSIUM IN SKIN DISEASES.**—GREVE (*Nordisk med. Arch.*, xiv., No. 1, 1882) recommends large doses of iodide of potassium in skin diseases, especially psoriasis. He begins with a mixture of iodide of potassium, 10.00 to 300.00 water, of which he gives a tablespoonful three or four times a day. Every time the prescription is renewed five grammes are added. He always increases the strength to 30.00 iodide to 300.00 water, and has, without inconvenience, given as high as 40.00 to 300.00. As soon as the dose of one gramme is reached, an effect is produced on the skin lesion. If the dose is limited to one gramme, or one and a half, the improvement is gradual, but if the amount is increased to 2.00 or 2.50 grammes, the improvement is rather rapid. The less affected parts of the face are first cured; next, the eruption on the neck,



chest, and back disappears; and last on the extremities, where shining cicatrices often remain because of thickness of the parts. Greve has given the drug both to adults and children, and never seen any injurious effect from its administration.—*Arch. of Dermatol.*, October, 1882.

**COMPLETE INVERSION OF THE UTERUS.**—At the meeting of the Cambridge Medical Society, held October 6, Mr. WHERRY related a case of complete inversion of the uterus. The patient was a woman who had been delivered two days previously of a healthy male child, which was born rather suddenly and with a short thick cord. She was given twenty minims of liquid extract of ergot after delivery, and shortly after this had a pain, and there was protruded from the vagina what at first appeared like the head of another child, but which proved to be the inverted uterus, with the placenta adherent. There was not much hemorrhage. The medical attendant detached the placenta and endeavored to replace the uterus by his hand, but he was obliged to desist, owing to the great softness of the uterine walls and the collapsed condition of the patient. Two days later, when called in, Mr. Wherry found the uterus completely inverted. Ether was administered, but it was quite impossible, owing to the doughy softness of the fundus, to replace the uterus with the unaided hand. Accordingly a large rubber drainage-tube was inflated to about the size of an egg at one end and ligatured. The hand, in the form of a cone, was passed into the vagina, and the finger tips, pressed against this air pad, were in no danger of lacerating the walls of the uterus. Half an hour's pressure, first with one hand, and then with the other, against the most prominent part of the fundus, at length reduced the uterus, leaving the dilated tube in the cavity. The string was then cut and the collapsed tube withdrawn. The replacement was not by a jerk, but gradual, and to be compared to the relief of a paraphimosis; it was evidently effected by squeezing fluid out of the œdematous tissues of the uterus. The patient, after three days of fever and pain in the body, made an excellent recovery.—*Lancet*, November 11, 1882.

**TREATMENT OF JOINT AFFECTIONS BY ELECTRICITY.**—Dr. A. JOFFROY, writing in the *Archives Générales de Méd.*, says that electrotherapy is only efficacious in cases of chronic arthritis, and is contra-indicated when the acute and subacute phenomena have not disappeared. In the joint affections of progressive chronic articular rheumatism, the results are but small; and when they are successful, they may be rather attributed to rest than to electrotherapy. In chronic articular rheumatism with uncertain localization and progress, and especially in the chronic forms of arthritis, consecutive on blennorrhagia, the puerperal state, or injury, more satisfactory results are obtained. The operation consists in fixing the positive pole of a continuous current battery, with from twenty to forty elements, either on the sides or on the upper or lower portion of the swollen joint, and moving about the pad representing the negative pole over the cutaneous surface. The skin becomes red and sensitive where the pad is applied. In the successful cases, the lesions were situated especially on the tissues surrounding the joint, which were indurated and resistant. There were neither fungosities, nor osseous lesions. This clinical fact explains why this treatment does not yield favorable results in gout and in chronic articular rheumatism. It is, therefore, especially in affections of joints, produced by wounds, by the puerperal state, or by blennorrhagia, but only after the disappearance of all the acute symptoms, that the continuous current may bring on either a complete cure, or at least a rapid improvement of the circum-

sticular changes and the restoration of movement.—*London Medical Record*, November 15, 1882.

**TÆNIA IN A CHILD SEVEN MONTHS OLD.**—Dr. SCHOPFT communicates this excessively rare case, occurring in a female child only seven months old, in whose fæces the proglottis of the *tænia circumcincta* were found. According to the most recent researches, the cysticerci of this tænia are found in dogs' lice, and the dogs become infected by swallowing the parasites. Consequently the appearance of this parasite can only be explained in persons who are brought into close contact with dogs. In the case reported it was found that the child had been accustomed to play with a dog affected with some skin disease accompanied by falling of the hair.—*Ann. de Gynéc.*, November, 1882.

**GONORRHOEAL RHEUMATISM.**—Dr. W. NOLEN terminates an elaborate article on gonorrhœal rheumatism somewhat as follows: While occasionally gonorrhœa is complicated by a rheumatic affection, such cases are very rare in proportion to the immense number of cases of gonorrhœa not so complicated, and even when present, the rheumatism may be of the most diverse nature and intensity, and possesses no distinctly characteristic features. It seems to be fairly well established that when once an attack of gonorrhœa is complicated by rheumatism, it is also present in subsequent attacks, indicating the probability, in some unknown manner, of the causative action of the gonorrhœa; though it may also be held that the principal cause lies not in the gonorrhœa, but in the constitutional tendencies of the individual, the simultaneous occurrence of gonorrhœa and rheumatism being merely coincidences.—*Deutsches Arch. f. klin. Med.*, November 8, 1882.

**INTESTINAL STRANGULATION; LAPAROTOMY; CURE.**—In the presence of intestinal obstruction by volvulus, invaginations, or adhesions, choice must be made, according to M. LÉON LE FORT, between enterotomy and laparotomy. He prefers the latter procedure, because it, equally with the former, permits an escape of the obstructed intestinal contents, and enables the removal of the cause of the obstruction. In support of this opinion he cites the case of a young man of eighteen years, who for six days had suffered from the symptoms of strangulation. M. Le Fort performed gastrotomy under chloroform, an incision 15 centimetres long being made in the linea alba from the umbilicus to just above the pubis; the peritoneum was then opened and the intestines carefully searched for the obstruction, which was finally found in the form of an annular constriction formed by inflammatory adhesions, about 5 centimetres above where the ileum entered the cæcum. The constriction was divided, the intestines returned to the abdominal cavity, and the wound closed. One month later recovery was complete. The antiseptic method was not employed; compresses soaked in dilute camphorated alcohol being retained in position by a body bandage.—*Gaz. Hebdomadaire*, Nov. 10, 1882.

**LIGATURE OF THE EXTERNAL ILIAC ARTERY FOR FEMORAL ANEURISM.**—At the meeting of the Société de Chirurgie held on October 25th, M. BERGER presented a patient in whom a popliteal aneurism had been cured by digital compression on the femoral artery. Some time afterwards a second aneurism formed on the femoral artery at the point where the vessel had been subjected to pressure in the treatment of the popliteal aneurism. Ligature of the external iliac artery resulted in a cure.—*L'Union Méd.*, October, 31, 1882.

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## HOUSE-DRAINAGE.

IN a recent issue we presented the results of late investigations of the sewerage system of Philadelphia, and endeavored to illustrate thereby the defects which commonly appertain to most systems of sewerage as constructed at the present day in this country. At this time, we desire to call attention to an equally important subject, that of house-drainage, and the faults commonly connected with it, as exemplified by some of the methods pursued in Philadelphia, and elsewhere. Fresh interest has been given to the topic by the recent enquiries of Rudolph Herring, Assistant Engineer, of Philadelphia, and W. H. Baldwin, C. E., who acted under special authority of the U. S. Census Bureau. They show how, in the absence of specific sanitary regulations on the subject, the most pernicious errors creep into practice, and are repeated day by day, until at length they become more or less characteristic of the entire system.

Formerly, before the sewers were made use of for the conveyance of domestic waste, it was the custom to construct, on the lot in the rear of the dwelling and sometimes under a portion of the dwelling, deep cesspools, or wells as they are called, which were excavated down to the gravel-bearing strata, and lined, except at the bottom, with brick laid dry, so that the liquid portion of the contents might flow off through the pores of the soil. These wells were used for the deposit of excreta and chamber slops, and seldom needed cleaning on account of their depth and manner of construction. When cleaning was required, it was done by the "bucket and cart" system until recently, when the "odorless

system," by means of tank, pump, and hose, was introduced in its place.

Since the introduction and common use of water-closets, there has been a gradual development of a practice of turning all the wastes of the house into these cesspools, their connection with the water-bearing strata underlying the city being depended on for carrying away the liquid portion as well as a quantity of the more finely divided solid matter. In course of time, however, the pores of the soil become obstructed, the well fills up, and has to be emptied by mechanical appliances. The constant expense and annoyance caused by this need has led to the adoption of another device, namely, that of tapping the well at a convenient level and connecting it by means of a drain-pipe with the common street-sewer, so that the overflow is discharged into this outlet. To prevent the accumulation of solid matter and the occlusion of the overflow-pipe, the rain-water and bath-water are likewise turned into the well. This is substantially the plan of drainage connected with a large number of the older houses.

But this method of disposing of sewage is not alone confined to this class of buildings. In houses of more recent construction, especially such as are called "bonus houses," the drainage arrangements are constructed upon the same principle, except that the wells are not required to be deeply excavated, nor to have pervious walls and bottom. The plan is to construct a cesspool in the rear to serve for two houses. The rain-water as well as all the sewage from the houses are discharged into it. These cesspools are about seven feet deep, and four feet in diameter. They are walled up with brick, and are intended to be coated inside with cement, so as to be water-tight, but in most cases the bricks are laid dry, thus permitting the escape of liquid matter into the surrounding soil. Each well connects directly with the street-sewer by means of a terra-cotta pipe; or, as is more commonly the case, each well is connected with a terra-cotta drain placed under the alley-way between the rears of two rows of houses, which drain has its outlet in the sewer in the street. In other cases the cesspools are used solely for excreta and chamber slops, while the kitchen slops and surface drainage are allowed to flow over the surface of an alley-way in the rear of the house, or between two houses into the street-gutter, to find their way into the nearest street-gully. Most of the better class of houses have independent sewer connections, by means of iron or terra-cotta pipes, generally the latter, which are constructed above or beneath the cellar floor, and enter the sewer in front of the house, or are laid under the surface of the lot in the rear and connect with the sewer in the back street. Through these channels the entire drainage of the premises, including bath,

surface, and roof water, is conducted directly into the sewer, and the cesspool nuisance is avoided.

The plans mentioned above, serve to illustrate the common faults connected with the private disposal of domestic sewage. In the first place, the storage of excreta and other putrescible matter in close proximity to habitations, is a practice which is repulsive to our senses, and in a high degree detrimental to health, and as such cannot be too severely condemned. Even when water-tight and well-ventilated vaults are used, and their cleansing is periodically attended to, the practice is objectionable, from their liability, even with these precautions, to become nuisances in the course of time.

But this care in construction and management is the rare exception, the rule being to construct these receptacles in such a manner that as much as possible of their contents shall be carried away by percolation into the ground. The result is the pollution of the soil, air, and when wells for the supply of drinking water are in close proximity, the pollution also of this supply. Shallow cesspools connected with the street-sewer by an overflow pipe, into which kitchen wastes and bath-water, as well as excreta, are discharged, produce the same train of evils. It frequently happens that the outlet-pipe becomes obstructed, causing the contents of the pit to overflow and defile the surface of the ground, and even the foundations and cellar of the dwelling. When the drain-pipe has a separate connection with the sewer, the remedy is easily applied; but when it is a part of a system common to a large number of houses, an obstruction in the main drain is not so quickly remedied on account of the difficulty of locating the obstruction, and from want of agreement and united effort on the part of the numerous property owners. The result is the perpetuation of a series of nuisances of the very worst description, until the intervention of the health authorities is invoked in behalf of the preservation of the public health. Nothing short of complete reconstruction of the drainage arrangements, and the separate sewer-connection of each property, avails to abate the evils inseparably connected with this radically defective plan of house-drainage.

There are two or three phases of the evil consequences of the storage of household wastes upon the premises that may be briefly alluded to. The retention of this material in cesspools and its constant agitation at a moderately high temperature, caused by the influx of hot water and other substances favors the decomposition of the organic matter, and the evolution of noxious gases which escape into the surrounding atmosphere. In a thickly populated neighborhood where there are nearly as many depositories of filth as there are habitations, the combined

action of these mephitic vapors must have the effect of seriously polluting the air and rendering it offensive, if not unsuitable for sustaining the normal condition of the vital powers of the system. The occupants of such houses are also subjected to dangers arising from polluted soil and contaminated ground-air. Leaking cesspools (and there are few that cannot properly be embraced in this category) have the effect of loading the soil with impurities, and of imparting a deleterious quality to the air circulating through it. The aspiratory power of the warmer air of the house in most months of the year produces a current of vitiated air, from the sublying and surrounding soil, into the basement, whence it ascends throughout the house.

It is a well-known fact that one of the chief causes of the foul condition of the sewers is the discharge into them of decomposing excreta and other organic matter. If house-sewage escaped in a fresh state, and sewers were properly constructed so as to insure the ready and quick removal of this matter before decomposition sets in, the evils most complained of would be averted.

With regard to the plumbing arrangements of houses, there is nothing specially to report which is not common to almost all American cities. The best and the worst and all intermediate grades of work exist, as might be expected when the matter is left entirely in the hands of the owners of property and mechanics. Owners, as a rule, have not the special sanitary knowledge required in designing and supervising the work; and mechanics can hardly be expected to execute the most skilful labor when their financial success depends so largely on the greatest economy in construction. Their lack of knowledge of the correct sanitary principles of house-drainage, is also a very frequent cause of defective work. The remedy is found in the public regulation and supervision of house-drainage. This plan has been applied with great benefit in Providence, R. I., and has also recently been inaugurated in New York City. The regulations adopted by New York Board of Health may be found in full in our issue of November, 1881.

The evils which result from defects in plan and execution of house-drainage, as exemplified by the methods pursued in Philadelphia, are to be remedied: 1st. By prohibitory laws with regard to cesspools and pits of every description. 2d. By compulsory laws on the subject of sewer-connection where sewers exist; and in their absence, by the enforced adoption of the "dry-removal" system. 3d. By the systematic regulation and supervision by the civil authorities of the details of private drainage arrangements, and by periodical inspection by properly qualified public officers.



**POLYGONUM HYDROPIPEROIDES (WATER PEPPER, SMARTWEED).**

AMERICAN physicians seem hardly to appreciate the wealth of resources contained in our indigenous materia medica. The *hydropiper* is an illustration. This remedy is not even mentioned in our pharmacopœia. Yet the late Dr. Eberle, in his work on *Materia Medica and Therapeutics*—in its day a deservedly popular treatise—speaks of it as the most active and certain of the emmenagogues. The late Prof. M. B. Wright, of Cincinnati, held it in equal estimation, and during his long career prescribed it often with remarkable success.

There is a curious history connected with the introduction of this drug into medical practice. Eberle obtained his knowledge of it from a country practitioner, who made it the subject of his thesis as a candidate for the doctorate, at the medical school where Eberle then held the chair of practice. Successful experience with it induced him to give an account of its actions and uses in his therapeutical treatise, but he does not state the source of his information.

The activity of this drug is due probably to the presence of *polygonic acid*, which is contained in its congener, *Polygonum hydropiper*. It has very decided stimulant, even vesicating property, when rubbed into the skin, whence its common name—*smartweed*. As an emmenagogue, it is indicated in states of anæmia, functional torpor of the ovaries and uterus due to systemic depression, and is contra-indicated in the condition of plethora. It should be given for several days before the time for the menstrual molimen to begin. It need hardly be stated that the non-existence of pregnancy should be assured before prescribing this or any other uterine and ovarian stimulant.

Whilst the water pepper is thus indicated in anæmia and functional depression, its power to stimulate the uterine circulation renders it useful in menorrhagia, and in metrorrhagia due to relaxation of the uterine vessels. Sub-involution of the passive kind, with a sluggish circulation, cold hands and feet, and general depression, are also benefited by this remedy.

The form most convenient for the administration of this drug is the fluid extract, given from five to thirty minims, three or four times a day. Its taste is hot, pungent, and somewhat acrid, but when mixed with some glycerine and wine, it can be readily taken.

**THE GARFIELD BOARD OF AUDIT.**

It is a matter of honor, as well as of custom, that the indebtedness for medical attendance in the last illness should be promptly paid. The amount to which the bills in the case of President Garfield

have been "scaled" by the Board of Audit is totally inadequate to the services rendered, and this indisposition on the part of the Government to justly meet them is the foundation of another scandal, of which the people would gladly be spared the disgrace.

When President Garfield was shot, and his life was still hanging by a thread, our horror-stricken nation demanded that he should have the benefit of the united wisdom of the best surgical skill that was attainable. Drs. Agnew and Hamilton were, therefore, summoned to Washington the day after the assassination, and, in conjunction with the surgeons there, gave to the distinguished sufferer their sole care and unremitting attention during those weary days in which the eyes and sympathies of the whole world were centred at his bedside.

When Congress assembled, it properly expressed public sentiment in declaring that the personal expenses of the President, resulting from his assassination, should be assumed by the Government, and it promptly passed an appropriation for the payment of the funeral expenses; which, to the scandal of the nation, included a considerable sum for wine and cigars consumed by the Congressmen who escorted the remains from Washington to their final resting-place. And this Congress—the same which, in the "log-rolling" river and harbor bill, appropriated upwards of \$20,000,000 to be expended where it would do most good in promoting the reelection of its members—with considerable display of virtue, assumed that the Government ought not to appropriate so large a sum as \$65,000 in payment of the services of the surgeons who were summoned, at the request of Mrs. Garfield and members of the Cabinet, to attend the wounded President. After wrangling over the subject all winter, Congress finally decided to give to a "Board of Audit" \$35,000 with which to settle these accounts.

In making an estimate of the value of their professional services, Drs. Agnew and Hamilton explicitly stated that it was calculated at the rate at which they were ordinarily paid by well-to-do patients for services rendered out of the city and requiring the same amount of time. This was their only criterion, as no similar case has ever happened before, and God forbid that it ever happen again!

The Board of Audit received the bills, and then, in consonance with the expressed feelings of the body that created it, have "scaled" them down to \$20,500, and, as if to still further depreciate the services of the surgeons, they have awarded \$7000 to Drs. Boynton and Edson, who were employed in the case solely as nurses.

Such is the manner in which it is proposed that the nation shall remunerate the men who, at its demand, and at great personal sacrifice, without stop-

ping to ask who would pay them, or even whether they would be paid at all, dropped their private business and took charge of our wounded President, and at the same time accepted a weighty care, and well-nigh crushing responsibility, greater than which surgeons never before assumed. Under the circumstances they can much better afford to remain unpaid than to accept the paltry sum at which the Board of Audit estimates the value of their services.

#### A NEW BOGUS DIPLOMA-MILL.

WE had supposed that the bogus diploma institution in America was a thing of the past, but we have lately received a photograph of a diploma issued by the Bellevue Medical College of Massachusetts—an institution incorporated May 25, 1880, in accordance with the "Public Statutes relating to *Manufacturing* and other Corporations organized under General Laws." Consistently with its mode of origin, this mill has commenced to manufacture diplomas in a manner which would have done credit to the hydra-headed establishment of which Philadelphia has been so fortunately rid. The diploma, written in Latin, contains the usual salutation to all who may read, and confers the degree of Doctor of Medicine upon John Burton Thompson, *hominem egregium studiis optimis deditum*—a distinguished man, devoted to the noblest pursuits—and is signed by Rufus King Noyes, M.D., President, and May R. Eastman, Secretary, but without the signatures of any Faculty.

The nefarious practices of this new-fledged diploma-mill have been uncovered by the vigilance of the State Board of Health of Illinois, which, under the direction of its active Secretary, Dr. John H. Rauch, has probably done more to break up the irregular issue of medical diplomas than any other body. The result was accomplished much as Mr. John Norris, of the Philadelphia *Record*, secured the overthrow of the diploma traffic in this city. A letter was sent, purporting to have been written by one V. B. Kelly, accompanied by an essay on "Vaccination," which, with the letter, was such a marvel of bad spelling that it should have betrayed its real purpose to a man of ordinary mental acumen. Under the plea of poverty, the writer applied for a "diplomy" without being put to the expense of attending lectures, and, after very brief negotiation, one was sent to him by express, C. O. D., for \$150.

We have seen it somewhere stated in the daily press that Rufus King Noyes, M.D., disclaimed any knowledge of this practice of the school of which he appears as President; but the methods of advertising pursued on his business card, and a certain local notoriety he has made for himself in Lynn, Mass., as an antivaccinationist, betray his tendencies, if not his real character.

We sincerely hope that the Commonwealth of Massachusetts will act more speedily than did our own State authorities in repealing the charter of this disgraceful *manufacturing* establishment, and deal promptly with the offenders, as they must be, against the law of the State. In the meanwhile we are glad to learn that the government authorities have secured the arrest of Eastman for violating the U. S. postal laws.

#### WILL THE NEW YORK CODE BE MAINTAINED?

THE medical profession of the country, from Maine to California, have, with absolute unanimity and in terms not to be mistaken, expressed their unqualified disapproval of the New Code adopted at last year's meeting of the New York State Medical Society, and the medical press, with but two exceptions, have correctly represented professional sentiment on the subject. The *Medical Record* and the *New York Medical Journal* alone have championed the New Code, and sought to lead the profession to giving its countenance to charlatanry, but their teachings appear to have in no wise swerved professional morals or influenced professional opinion, not even in their own State. Outside of the City of New York, the New Code seems to be without support, at least if we can judge by the fact that thirty-three of the county societies have formally repudiated it, and but two have accepted it. It is, therefore, no longer a question of doubt that a great majority of the delegates to the State Society are opposed to the New Code, and it only remains to be seen if, at the approaching meeting, the large pledged delegation from New York City can, on a required two-thirds vote, override the will of the rest of the State.

#### BODY-SNATCHING.

As we go to press we learn that, through the enterprise of one of our city newspapers—*The Press*, a colored man and two wagon-drivers have been arrested for robbing graves in one of our cemeteries. We have only space at this time to express in the strongest terms our condemnation of this crime.

The law of 1867 directs that unclaimed bodies shall be delivered to the medical colleges for dissection in proportion to the number of their students. Why, then, it may be very properly asked, should there exist any cause for body-snatching? The chief reason is, because the Coroner of this city persistently disregards and disobeys this law.

The number of subjects received from the Alms-house is utterly inadequate to meet the needs of the large number of medical students in the city, and the Jefferson Medical College, we have the best authority for stating, has in several years received

less than a dozen subjects from the Coroner, while his own private rooms for anatomical instruction have had an ample supply.

It is only a question of time when the Coroner must be compelled to obey the law of the Commonwealth, of which he is a sworn officer, or better still when he and his office shall be things of the past.

In commenting on the clinical teaching of obstetrics lately, we took strong ground in favor of it. As a forcible commentary upon this, we quote from a letter just written by a young medical friend—a recent graduate—now studying in Vienna, and we commend it not only to boards of guardians of the poor, but to the philanthropists who have at heart the best good of poor women. The rich can afford to pay for experienced able men, the poor cannot. But let our correspondent tell the result.

"I graduated without ever having examined a pregnant woman or seen a single delivery, and was licensed to go out and get experience at the expense of my earlier patients. But the first two weeks I was here [there are 10,000 births a year] I saw two craniotomies, several forceps cases, and numerous births, and in a month I have learned more of practical obstetrics than in a whole winter of didactic lectures. All that mass of material at the Almshouse is only of benefit to a very few men. That is the system that drives men abroad who wish to have some experience before they practice."

## REVIEWS.

**ESSENTIALS OF VACCINATION; A COMPILATION OF FACTS RELATING TO VACCINE INOCULATION AND ITS INFLUENCE IN THE PREVENTION OF SMALLPOX.** By W. A. Hardaway, M.D., Professor of Diseases of the Skin, in the Post-Graduate Faculty of the Missouri Medical College, etc. Pp. 146. Chicago: 1882.

THIS is a useful and timely work. Dr. Hardaway presents in a small compass the "essentials of vaccination," which must be regarded as a necessary, and as indeed an indispensable, duty, to be undertaken by some one. It is fortunate that the task has been undertaken by some one so well qualified to perform it as is Dr. Hardaway. The advantages of this libellus are obvious. It is small, condensed, and therefore within the reach of any one almost. The knowledge is accurate and well put. Those who read it cannot fail to receive correct notions. The hand-book of Dr. Seaton is an excellent work, but, compared with this, is both voluminous and expensive, and, besides, has for some time been before the profession without revision. Furthermore, Dr. Hardaway's book contains a good deal of matter of American origin. There are chapters on the history of vaccination, on variola in animals, on the nature of vaccinia, on vaccinia in the human subject, on abnormal modifications and complications of vaccinia, on revaccination, on the merits of different kinds of vaccine virus, on the methods of obtaining and storing the virus, on the operation of vaccinating, and, finally, an examination of the objec-

tions to vaccination. All of these topics are treated with sufficient detail, if somewhat sketchily. On the whole we can recommend the work to our readers as a useful and convenient treatise on this topic.

**ATLAS OF GYNECOLOGY AND OBSTETRICS.** Edited by DR. E. MARTIN, Prof. of Gynecology at the University of Berlin, and DR. J. P. MAYGRIER. Containing 475 plain and 35 colored Illustrations. THE EXPLANATORY TEXT, TRANSLATED AND EDITED, with ADDITIONS, By WM. A. ROTHACKER, M.D., Pathologist to the Cincinnati Hospital, Ohio. Cincinnati: A. E. Wilde & Co.

THIS atlas consists of fifteen parts, each containing four plates and four pages of explanatory text. In all, there are over four hundred illustrations, many of them beautifully colored, and covering completely the subjects of gynecology and obstetrics. Many of these are reproduced from the well-known *Hand Atlas* of Dr. A. Martin, of Berlin; the remainder are lithographic copies of Maygrier's *Nouvelles Demonstration D'Accouchements*. This American edition is translated and edited by Prof. Wm. A. Rothacker, pathologist to the Cincinnati Hospital, the explanatory text of the obstetrical portion being written altogether by Dr. Rothacker. Such drawings are of great value to all students and practitioners of gynecology and obstetrics, and will prove almost indispensable to teachers of these branches of medicine.

## SOCIETY PROCEEDINGS.

PATHOLOGICAL SOCIETY OF PHILADELPHIA.

*Stated Meeting, November 23, 1882.*

THE PRESIDENT, JAMES TYSON, M.D., IN THE CHAIR.

GREAT HYPERTROPHY OF THE HEART DUE TO SEVERE VALVULAR LESIONS.

Presented by DR. M. O'HARA.

J. K., male, æt. 30 years, laborer, contracted syphilis when 18 years of age. Health good until within past three years, when he began to suffer from pain in the left breast, palpitation of the heart, and slight dyspnoea after violent exertion. Gradually becoming worse and unable to work, he was admitted into St. Mary's Hospital in June, 1882. He then complained of great pain over the upper part of the sternum, in the left arm, and shoulder. He lost considerably in weight, his appetite was poor, and albumen was present in small proportion in his urine, although casts were absent. He had marked dyspnoea on admission, which increased rapidly until sleep could only be obtained in the upright position. There was no evidence of pulmonary trouble. With the forearms flexed to a right angle the brachial arteries became prominent at each impulse of the heart; the pulsation of the carotids was wavy and prolonged; the temporals were tortuous and visibly pulsated; no retinal arterial pulsation was seen. Retinal venous pulse was marked, but no visible venous pulsation was detected elsewhere. The left præcordial region was specially prominent. The apex beat was most distinct in the sixth and seventh interspaces on a perpendicular line running midway between the left nipple and anterior border of the left axilla. The heart's impulse was usually forcible and diffused, but at times it became weakened and wavy. In the second left intercostal space a systolic impulse was observed. The pulse rate varied from 80 to 120 per minute, struck the finger with considerable force, but at once lost



most of its volume. All these phenomena were exaggerated by raising the hands above the head. The radial pulses were unequal, but the brachial arteries presented no differences. No hepatic pulsation was felt. The cardiac area of complete dulness was nearly twice its normal size, the increase being downward and to the left. Over the second right costo-sternal articulation, the closure of the aortic valves was distinctly heard, and with this a slight diastolic murmur. A systolic murmur was also heard over the same spot. The systolic murmur was nearly lost in the carotid and subclavian arteries, but the diastolic one remained distinct. On a line with the second costal cartilage, over the sternum and to the left of this bone, the diastolic and systolic basic murmurs were most intense. Over the cartilage of the left fourth rib, the murmurs heard at the base of the heart were less distinct or were obscured by the development of other murmurs. In this situation a short, sharp, presystolic murmur, apparently prolonged into a systolic one, was detected. At the apex and just above it, the systolic murmur became intensified, its blowing character aiding in differentiating it from the short, harsh murmur which immediately preceded it. From the fourth to the seventh rib, and from the sternum to a point about five or six inches to the left, a diastolic murmur of considerable intensity was heard. The character of the diastolic murmur over this area was different from that presented by the second sound murmur at the base of the heart, and its intensity was much greater. Posteriorly, at the lower angle of the left scapula a blowing systolic murmur, entirely deprived of its harsh presystolic complication, was heard. Dr. Eskridge thought the physical signs justified him in venturing the diagnosis of constriction and regurgitation at the ventral orifice; a rare form of aortic regurgitation produced by the inability of one of the aortic semilunar valves to close while the others acted properly; great hypertrophic dilatation of the left ventricle, and to a less extent of the left auricle; and aneurismal dilatation of one of the great vessels, probably of the pulmonary artery near its origin from the heart. The patient rapidly sank, œdema of the lower portion of the trunk and lower extremities, with hydrops pericardii, of the pleura, and of the peritoneum, developed. He died exhausted in August, nearly two months after admission to the hospital.

*Sectio-cadaveris.*—Brain: Some venous congestion of the pia-mater. The brain substance and the ganglia nearly normal in appearance. Thorax: The pericardium was nearly filled with serum. The only evidences of inflammation were a few patches of recent lymph at the left anterior upper portion of the sac. The heart weighed eighteen ounces, the increased weight being chiefly due to eccentric hypertrophy of the left auricle and ventricle. The right ventricle was dilated, with slightly thickened walls. The aortic valves were insufficient and thickened. The posterior leaflet was normal in shape, but the others curled upon themselves on the aortic side of the orifice. The stenosis was slight. The mitral orifice was button-hole shaped, and the valves failed to close on account of calcareous deposits in their tissues, this degeneration also involving the inner surface of the left side of the auricle contiguous to the valves. The auricular surface of the valves was fairly smooth, but in the ventricle just beyond the valves, and attached to them, hung a bony substance about one-eighth of an inch in diameter. The left auricular appendix was much hypertrophied. The valves at tricuspid and pulmonary orifices were normal. The pulmonary artery was considerably dilated. The pleural cavities contained several ounces of serum. There were old adhesions at the apex of the right lung posteriorly, and at the same part of the left lung anteriorly. Several patches of recent lymph were

also found at the lower part of the left pleural cavity. Abdomen: The peritoneal cavity contained considerable serum, and its veins were engorged. The liver was enlarged, with distended veins. The kidneys were highly congested. The spleen was double its normal size and softened.

ABSCCESS OF THE LIVER FOLLOWING ARRESTED MENSTRUAL DISCHARGE FROM EXPOSURE TO COLD; PYÆMIC ABSCESSSES OF THE LUNGS AND SPLEEN; PERFORATION OF THE BOWEL; SEVERE HEART COMPLICATIONS; DEATH DURING THE SEVENTH WEEK.

Presented by DR. J. T. ESKRIDGE.

M. D., æt. 28 years, was a factory girl, whose father and two sisters had died of heart disease. She had had two attacks of inflammatory rheumatism, but had never complained of heart trouble. Her fatal illness began at night, by arrested menstrual flow, and severe cramping abdominal pains, coming on after exposure to cold during the previous afternoon. Fever and pain in the right lower side of the abdomen continued for three days, when she was able to work again for about a week. Jaundice began early, was well marked during the first three weeks, was slight afterwards, but lasted until her death. Her symptoms three weeks after the beginning of the attack, when admitted into St. Mary's Hospital in Dr. Hickman's ward, were: great prostration, emaciation, loss of appetite, pain in the right inguinal and lumbar regions, and irregularly recurring chilly sensations. Two weeks later, when first seen by Dr. Eskridge, the liver dulness extended nearly to the anterior superior process of the ilium, and the normal tympanitic note of the right inguinal region of the abdomen was replaced by one bordering on dulness. The tenderness was so great that neither fluctuation nor a tremor could be detected, if such existed. Great tympany soon developed and obscured the physical signs. A pyæmic condition, from which the patient perished in about two weeks, set in, attended by chills, fever, sweating, low temperature, and diarrhoea. A few days before death she passed considerable pus by the bowels. The surface temperature, taken over the chest and abdomen, showed the latter to be about two degrees warmer than the former, but all parts of the abdomen were of nearly the same temperature. Stenosis of the aortic and mitral orifices, with insufficiency of the valves of the latter, and a dilated hypertrophy of the left auricle and ventricle, were recognized during life. The post-mortem examination revealed the diagnosed lesions of the heart, and demonstrated the possibility of visible left auricular pulsation. The liver weighed eighty ounces (the right lobe being alone enlarged), and contained a large abscess surrounded by several smaller ones with which it was connected. The cæcum and its appendix were surrounded by about six ounces of pus, the latter being circumscribed by adhesions. Two openings were found in the black and gangrenous cæcum, one where its appendix had sloughed off, the other due to perforation of the bowel by the pus. The portion of the liver external to the hepatic abscess was firmly adherent to the abdominal wall, and from this point (about two inches above the crest of the ilium) the pus had burrowed its way and formed a sinus leading to the right inguinal region under Poupart's ligament. A direct communication between the liver abscess and the accumulation of pus surrounding the cæcum was seen.

DR. ESKRIDGE thought that the demonstration of the possibility of visible left auricular pulsation in the second left intercostal space, and of the occurrence of a functional murmur in the pulmonary artery without dilation of that vessel, was worthy of notice at present, as Dr. Broadbent had so recently advocated views almost diametrically opposite. Dr. Eskridge considered

mitral stenosis of not infrequent occurrence, and said, with care, the mitral presystolic murmur was not usually difficult to detect. The four physicians, including himself, present at the autopsy, then thought that the hepatic abscess was secondary to the inflammation and suppuration around the appendix and cæcum, but he, after carefully analyzing the clinical evidence and pathological lesions in favor of each condition, was satisfied that the case began as one of primary abscess of the liver following exposure to cold while the patient was menstruating.

The discussions on both these preceding specimens, which presented somewhat similar heart lesions, was now opened by DR. J. C. WILSON, who said that there was one point of special clinical interest in Dr. Eskridge's case, viz., the chronology of the lesions. He thought that the extensive multiple abscesses of the liver and lungs were secondary to the abscess around the caput coli. In some cases the determination of the primary source of the emboli was difficult, but in this case it was perfectly clear.

DR. BRUEN said that he would like to go on record among those who had observed auricular pulsation in cases of mitral obstruction, in which the stenosis was extreme.

DR. NANCREDE remarked that in his experience flexion of the thigh on the abdomen was an almost invariable early symptom in cases of perityphlitis, from which he would infer, that as this thigh flexion did not occur in Dr. Eskridge's case until within ten days of the fatal termination of the case, that the peri-cæcal abscess was secondary to that in the liver.

THE PRESIDENT said that he had been much impressed with the marked increase of the surface temperature in the neighborhood of the abdominal abscesses as compared with the general body temperature. As to the chronology of the various affections, he was inclined to believe that Dr. Wilson was correct.

DR. ESKRIDGE said, in reply to Dr. Wilson, that he could appreciate how the perityphlitis might be mistaken for the primary trouble, and the hepatic suppuration for the secondary; such a mistake (for he felt certain that the abscess of the liver was the primary affection) was made by all, including himself, who were present at the post-mortem examination. The pathological and clinical facts in favor of primary hepatic abscess were given at some length in his remarks in connection with the presentation of the specimens. In brief, the clinical features were as follows: Deep and early jaundice following exposure to cold, pain in the right side of the abdomen attended by fever and gastric irritability of a few days' duration; an intermission of a week, during which she was able to work, followed, after which gradually increasing weakness with dull, abdominal pain, attended by loss of flesh and appetite confined her to bed; ten days before death the development of intense tympany associated with flexion of the right thigh upon the abdomen. The hepatic suppuration was confined to the right side of the right lobe, all the smaller abscesses directly communicating with the large one, and the left lobe of the liver being apparently healthy.

#### TONGUE AND LARYNX FROM A CASE OF ELEPHANTIASIS GRÆCORUM.

Presented by DR. A. C. W. BEECHER.

The case from which these specimens were removed was reported in the *Photographic Review of Medicine and Surgery*, No. 6, vol. i., August 1871. Mr.—, æt. 26 years, born in Cuba, of Spanish parents, married. His father was living when the patient died in 1872; the mother died when he was an infant. He was wet-nursed by a colored house-servant, who was unmarried, but had had several children by different individuals.

She was healthy as far as known, with the exception of sores upon her feet. He had none of the diseases of early life except measles and mumps. His health was good up to 15 years of age, when superficial yellowish-pink spots appeared upon his body, accompanied by neither pain nor itching. They remained about one year, and disappeared during a voyage to Spain. While there he was attacked with neuralgia of the little fingers, extending along the course of the ulnar nerve to the elbow, which was relieved, and he returned to the West Indies. Six months after his return he experienced a second attack, which lasted for one month. In 1862 he came to this country to study, and after one year became the subject of repeated catarrhs, chiefly affecting the throat. Itching of both forearms and legs soon after developed. In 1866, œdema of the hands and feet, which did not extend beyond the wrist or ankle, set in, producing a sensation of stiffness of the fingers and toes. Blebs then suddenly appeared in varying size upon the dorsum of the hands and fingers, extending over the whole length of the latter. At times a sharp pain in the hands and fingers, arousing him from sleep, would herald one of these bullous attacks. The bullæ contained a whitish opaque fluid, and when burst were succeeded by dark-brown scabs, transversely cracked and fissured over the finger joints. Under these crusts were excavated ulcers. The finger-tips and the ends of the toes presented similar ulcers, over which the nails grew, and these latter being brittle broke off when long. Next frequent hemorrhages from the nose, coming on while laughing, or in mental or physical excitement, were noted. The nose became tender, was much swollen, and discharged moderately offensive pus, and the bridge of the nose began to sink, gradually assuming its present appearance (a photograph was here shown). A year after the hands were attacked the face became similarly affected, the ulcers on healing leaving distinct cicatrices. The eruption never entirely ceased, new bullæ and ulcers forming while others healed. There was marked emaciation. The hair, which was everywhere scanty, was absent in many spots on the body, and the skin was of a dusky hue. The muscles of the arms were much wasted, and the skin presented small white cicatrices. Over both patellæ and olecranon processes, large, hard, firm, reddish nodules were seen. The hands were much deformed, with wasted, contracted fingers, having numerous small hard tubercles scattered beneath the skin of the dorsæ of the hands. Numerous ulcers, mostly covered with irregular black scabs, covered the back of the fingers. A markedly varicose condition of the veins near the wrist was observed. The hair of the head was normal in quantity, but was hard and harsh, while there was total loss of eyelashes and eyebrows, and the beard was scanty. There was a large hard tubercle over one frontal boss, near which was an old ulcer. The nose was much sunken, there was an ulcer over the right zygoma covered by a black rupia-like scab; the face was marked with scars, and the ears were likewise deformed with traces of numerous cicatrices. Many of the teeth were decayed and broken off close to the gums. The tongue was much thickened with greatly enlarged papillæ. The velum palati was almost gone from ulceration, and yellowish-white tubercles existed in the pillars of the fauces. The larynx was much contracted by thickening of its mucous membrane. The epiglottis was about twice its normal thickness and had several well-marked tubercles upon it. The voice was much impaired, weak, and had a peculiar husky sound. There were deep sloughing ulcers over each tendo Achillis. Tactile sense was very much impaired, as in the dorsum of the hands, where the sense of touch was almost absent, and what was recognized was referred to some point in the neigh-

borhood of the point of contact. The sense of pain was almost entirely absent in the hands and forearms, becoming more marked as the body is approached; a pin passed through the pulp of the middle finger gave absolutely no pain. The difference between very hot water and that of an ordinary temperature was readily perceived; moreover, there was general increased cutaneous sensibility to temperature changes. Taste and smell were somewhat impaired. Very slight anæsthesia of the trunk exists. Sight was good, although prolonged use of the eyes was painful. The general health of the patient was fair. There seemed to be no trace of venereal disease. Sexual power was absent. Frequent neuralgic pains of the legs and arms were complained of. The atrophy of the hands, feet, fingers, and toes was appreciable from month to month. The cornea next became ulcerated, the conjunctival surfaces became adherent, and almost total blindness ensued. Swallowing was almost impossible towards the last, owing to the pain produced by the throat ulcers and because from imperfect closure of the rima glottidis fragments of food lodged in the larynx, producing violent and exhaustive coughing. Respiration was also so much impeded that he died October 29, 1872, partly from dyspnoea, partly from starvation. Up to death he suffered intensely.

*Autopsy.*—Rigor mortis well marked; great emaciation of the entire body noted. The surface of the tongue was fissured, the papillæ enlarged, with the remains of tubercles well marked toward its base. The epiglottis was curved on its long diameter, thickened, and stiff, with its upper margin eroded by a large ulcer. A deep ulcer was situated in the mucous membrane near the apex of the left greater cornua of the hyoid bone. Narrowing, from thickening of tissues, involved the trachea at its upper part, and produced such a stenosis of the chink of the glottis that an ordinary quill could not be passed between the vocal chords. Upon section of both ulnar nerves near the elbow, extensive degeneration was detected. This case was examined both by Dr. Duhring and Dr. R. Bartholow—the latter making a laryngoscopic examination—who both considered it to be of the mixed variety, viz., tubercular and anæsthetic leprosy. The case is interesting both from its rarity and the possibility of other cases being brought here from California and New Brunswick, in both of which places it is not uncommon. Again, its resemblance to syphilis at first led him into error, although Dr. Beecher said that he had recognized something strange about the disease. The late Dr. Maury saw the case with me, and had no doubt of its syphilitic nature until Dr. Duhring's examination of the case convinced him that it was really leprosy. Erasmus Wilson says: The resemblance to secondary syphilis is so striking that an error is certain, excepting on the part of those who have had an opportunity of seeing and observing leprosy.

DR. WILSON asked whether the family history had been investigated.

DR. BEECHER replied that he had carefully questioned all concerned, but had ascertained nothing special, except that when such cases occurred in wealthy families the fact was always hushed-up.

DR. WILSON said that in this connection he would call the attention of members to a very able article in the last issue of *The American Journal of the Medical Sciences*, where the writer took the view that leprosy was contagious, maintaining that it should be investigated where it was of rare and recent occurrence. Dr. Wilson also referred to its occurrence among recent immigrants in certain of our northwestern States.

DR. CARL SEILER said that Dr. Beecher had asked him to examine the specimen of the larynx and tongue of the case of elephantiasis. The dorsum of the tongue

was deeply furred and the papillæ appeared enlarged. The epiglottis was thickened, very stiff, and rolled on its long axis like a leaf. On its upper free margin was a crescentic ulcer with raised edges, and numerous small roundish ulcers were scattered over the laryngeal surface of the epiglottis. Extensive ulceration of both ventricular bands and vocal cords existed, so that the opening of the ventricles was almost entirely occluded. The ulcers were symmetrical and most marked towards the anterior insertion of the vocal cords. About a quarter of an inch below the cords was a cicatricial band projecting from the sides of the subglottic cavity, and leaving an elliptical opening through which a crow-quill could hardly be passed. Below this obstruction the mucous membrane of the subglottic cavity was studded with small round ulcers, while the trachea seemed healthy. No further lesions could be detected by the naked eye, although, doubtless, such had existed, but had been obscured owing to long preservation in alcohol. Dr. Seiler regretted the absence of the records of the laryngoscopic examinations made before the patient's death; still the lesions seen in the specimen would explain the symptoms of dyspnoea, aphonia, and dysphagia, and it was astonishing how the patient could have respired at all through the narrow opening left by the cicatricial tissue below the glottis. The chief interest, however, centred in the great similarity of the lesions in this unique case with those found in syphilis and lupus of the larynx. He had seen ulcerations in syphilitic laryngitis almost identical in shape and location with those seen in the specimen, and he remembered having seen two or three specimens of lupus of the larynx, when in Vienna, which bore a strong resemblance to syphilis. Lupus and leprosy of the larynx could not be diagnosed from one another by laryngoscopic examination, but other signs and symptoms outside of the larynx had to aid in the diagnosis. Thus in a syphilitic laryngitis there were always sharply defined bands of a deep red color on the free margin of the velum palati. In lupus, affections of the skin of some part of the body always preceded, co-existed with, or shortly followed the manifestations of the disease in the larynx, while in leprosy the larynx was usually attacked later in the disease when other portions of the body clearly showed marks of the pest.

DR. LITTLE remarked that, having conversed with Dr. F. H. Enders, who had seen a great many cases of leprosy in the Sandwich Islands, he had been interested to note that the eyelids were affected in the early stages, ectropion resulting, and the conjunctiva and cornea, or even the whole eyeball, becoming involved. The affection of the eyelids is sometimes the first symptom, or occurs during the first or second year of the disease. The lids were involved in the case described, and the eyeballs subsequently.

## NEWS ITEMS.

### CINCINNATI.

(From our Special Correspondent.)

**SMALLPOX IN CINCINNATI.**—A recent issue of an Eastern daily paper contains a statement that "the ravages of smallpox in Cincinnati have been withheld from the public," and that "since August 24 there have been four thousand cases, of which fifteen hundred were fatal." The law requiring the registration of infectious diseases is strictly enforced in this city, so that your correspondent experienced no difficulty in obtaining the correct figures, which completely refute the above statement. The records of our Health Office show that since the first appearance of the disease, in January, 1881, a period of twenty-two months, only



4,000 cases have occurred, and of these, 1248 proved fatal. In the month of August, this year, there were 90 deaths from smallpox; in September 70, and in October 36. The disease has rapidly decreased, until, at the present date, there are only 20 cases in this city of 300,000 inhabitants, and these are confined to the German districts, where the greatest difficulty is encountered by the authorities in their efforts to secure general vaccination. In these portions of the city there will, of course, be more or less smallpox during the coming winter, but all attempts to magnify this small number into a general epidemic are unjust to the city, the general health of which is quite good. Your readers should not be misled by the frequent reference in the daily and medical press of this city to the bad character of our Board of Health. It is at present an unusually incompetent collection of ward politicians, and deserves to be abolished; but its members have interested themselves chiefly in the management of the funds of the board, and the distribution of minor offices, fortunately leaving the control of smallpox affairs in the hands of the Health Officer, who has done all that could be reasonably expected of him.

## CHICAGO.

(From our Special Correspondent.)

**THE MEDICAL SCHOOLS.**—The reputation of our city as a medical centre of instruction is fully maintained this year by the number of students, which is between 800 and 900, distributed amongst the four regular medical schools. The Woman's Medical College, as far as we know, the largest in the West, has the respectable number of 75 matriculants. Rush College, the oldest, claims the lion's share, with nearly 500 students, while the Chicago Medical College and the College of Physicians and Surgeons each have about 140.

The College of Physicians and Surgeons, though only opened this autumn, owes its fair start in numbers in no slight extent to the reduced fees, which are but half of those of the other institutions. But it has to contend with unfavorable auspices from the onset. Built near the County Hospital in the hope of using it for clinical purposes, the prospect has been somewhat marred by the action of the County Commissioners, who have control of the Medical Staff of the County Hospital. After long efforts the new school succeeded in being represented on the staff by one member of its faculty. However, other restrictions on the part of the County Board have rather diminished the availability of that hospital for clinical demonstration.

**BOGUS DIPLOMAS.**—A new medical hatching machine has been discovered by the State Board of Health, who refused to admit to practice a certain Dr. Thompson, whose diploma was signed by the President of the "Bellevue Medical College of the State of Massachusetts," of Boston. Bogus letters were sent to the alleged Dean, Dr. Rufus Noyes King, in which the correspondent, with a strenuous attempt at illiteracy and knavery, asked for information as regards the terms of graduation in that school. The *bona fide* answer is fully up to the questioner's epistle, in both the above-mentioned qualities, and revealed a diploma factory in the Buchanan style, in which instruction is given (if desired?) with special reference to diagnosis, treatment, and doctoral conduct. To satisfy all possible demands, the corps of instructors is said to consist of representatives of the two medical schools. Dr. Thompson is as yet without license.

**THE HEALTH OF THE CITY** was seriously threatened by a fresh outbreak of smallpox in October, traceable to a few concealed cases. By strict vigilance, however, the Board of Health has become master of the situation, and very few cases of the disease have made their ap-

pearance since. Scarlet fever was also alarmingly prevalent, though of a mild type. This likewise has diminished, and the mortality reports now show a better sanitary condition of the city than has existed for several years.

## ANN ARBOR, MICH.

(From our Special Correspondent.)

**THE CHARGES AGAINST PROF. FROTHINGHAM.**—A matter of more than usual interest has attracted the attention of the medical profession and the laity of Michigan. Briefly it became public through a written complaint made to the President of Michigan University, at Ann Arbor, by a student of the medical department, against Dr. G. E. Frothingham, Professor of Materia Medica, Therapeutics, and Ophthalmology and Otology. The complaint against the Professor was that he took the time of the students in denouncing religion, churches, and ministers. The student who made it has for years been a missionary on the Pacific coast, and is about forty-five years old. For a year and a half he has been at the medical department of the University. Prof. Frothingham denied the charge, and in turn arraigned Mr. Morgan, the complaining student, before the Medical Faculty as having in his complaining letter to the President been false in both spirit and letter. The Faculty met, heard both the accuser and accused, and witnesses on both sides, and decided that the charges of Prof. Frothingham against Mr. Morgan were not sustained. Five of the Faculty were present at the meeting which rendered this decision. The names of the majority are understood to be Professors Dunster, Langley, and Herdman; the names of the minority are Profs. Palmer and Sewall. Profs. Ford, Maclean, and Prescott were not present.

Prof. Frothingham now announced that if the matter was to be left in this way he would resign. Prof. Maclean said that he would do likewise. The Medical Faculty then held another meeting in which they passed resolutions to the effect that 1. Mr. Morgan in entering a complaint against Prof. Frothingham violated one of the University laws and stepped beyond his privileges; 2. Mr. Morgan, in his letter to President Angell exaggerated and misrepresented many important points in his charge against Prof. Frothingham; 3. The Faculty in voting upon these resolutions does not wish to impeach the veracity of any student or witness concerned.

In view of this action of the Faculty Prof. Frothingham has concluded not to hand in his resignation at present, and of course Prof. Maclean will do likewise.

Such in brief is an outline of this quite remarkable transaction. It is possible that we have not yet heard the end of it.

## VIENNA.

(From our Special Correspondent.)

**SYNTHESIS OF URIC ACID.**—An important discovery in physiological chemistry has recently been made in the chemical laboratory of Prof. E. Ludwig, by Dr. Horbaczewski.

Prof. E. Ludwig announced the discovery for the first time in the Society of Physicians, upon the evening of November 3d. Dr. Horbaczewski heated urea and glycol very quickly up to 230° C., and then allowed the two substances to fuse until evolution of gas ceased. A brown mass resulted, from which uric acid was separated by a very complicated process.

Uric acid, as thus obtained, presents under the microscope the characteristic whet-stone shaped crystals, and when tested chemically reacts in a perfectly satisfactory manner.

This discovery of Dr. Horbaczewski is the first synthesis in physiological chemistry that has ever been

made. It will be remembered that in 1828 Wöhler succeeded in the formation of uric acid from ammonium cyanate. This discovery was not a synthesis, in the true meaning of the word, inasmuch as a more complex combination of elements was not built up from simpler combinations. Then, again, Dr. Horbaczewski formed uric acid out of urea and glycolic acid, two substances found normally in the living human body.

Since the evolution of the formula for uric acid,  $C_5H_4N_4O_6$ , by Wöhler and Liebig, in 1828, the problem which the young investigator in Vienna has solved has been the occasion of infinite toil in all chemical laboratories. Mulder, Bayer, and Streichen have worked in vain upon the subject. Bayer's pseudo-uric acid, produced by the reaction of cyanamide upon alloxantin, reacts under the murexide test, but fails in other characteristics. Streichen's experiments with glycolic acid certainly pointed the way to the discovery.

Prof. Bayer has telegraphed his congratulations from Munich. While the significance of this discovery is great as an absolute fact in physiological chemistry and biology, it will probably lead to important results in clinical medicine and therapeutics.

**PROF. CARL BRAUN CHALLENGED BY AN AMERICAN PHYSICIAN TO FIGHT A DUEL!**—A popular medical journal appeared upon last Tuesday with a very sensational account of a quarrel between Prof. Braun and an American physician, who has been engaged, for some time, in the special study of obstetrics.

According to the story, the American, after breaking the arm of a child, with dorsal displacement of the right arm, in a fooling presentation, absented himself from the clinic, fearing to encounter the irate Professor's very excellent German or equally vile English. Prof. Braun's remarks were reported by a colleague, who did not understand German, to the operator. Prof. Braun applied the term "feigheit" (*i. e.*, cowardice) to the young man's conduct in a perfectly playful manner, and only desired to impress upon the young man's mind that he had not necessarily been guilty of an awkward operation.

The American thoroughbred ("Amerikaner vollblut") became highly incensed, and in company with a comrade repaired to Prof. Braun's residence, in London Gasse, charged him with the insult, demanded an apology before the college or a duel with pistols at ten paces at Schön-Brun.

Professor Braun endeavored to calm the hot-headed youth, refused to make a public apology, and stated that, whatever American social laws might be, it was not a custom in Austria for a professor to fight with his students. Not at all satisfied with the result of this interview, the American betook himself to Judge Taft, the American Minister, and unburdened his tale of woe. After mature reflection, Judge Taft concluded that the Professor was not altogether in the wrong, thought the occurrence was not a sufficient *casus belli* between America and Austria, and begged the American to let the matter drop.

All the Vienna daily papers caught up the item at once, and the affair has been town-talk for a week. The North German papers have heard of the matter, also, and our American friend has achieved, within a very short time, a great notoriety.

Your correspondent knows the American physician and Professor Braun, and from the lips of both, is able to assert that the whole story is a fabrication, a typical example of Teutonic wit.

**FAREWELL LECTURE OF DR. O. W. HOLMES.**—Dr. Holmes delivered his farewell lecture before the medical class at Harvard, on Tuesday, November

28th. One o'clock, the hour for the anatomical lecture, found the amphitheatre packed with students of all classes. Among them many gray-haired practitioners were assembled to hear their old teacher give his last lecture. The Medical Faculty occupied seats within the rail. In front of the desk was a large plaque of flowers about three feet in diameter. The entrance of the doctor was marked by the rising of the students, and as their applause ceased, Mr. Washburne, on behalf of the class, presented him in behalf of his last class with a beautiful loving-cup, inscribed with a quotation from one of his own poems. Mr. Washburne said: Dr. Holmes, it is with deep regret that we come to this farewell. We had hoped, when we entered upon our course to be permitted to listen to your lectures through the year. But we are thankful that we have enjoyed this privilege at all. Desiring to express our regard in some form more tangible than mere words, we beg you to accept this gift. As you may look at it, we hope you will sometimes remember us as we shall always remember you. In the language of the inscription, "Love bless thee, Joy crown thee, God speed thy career." A photographer was present, and while he was taking the scene the doctor had time to overcome his emotion.

There was three times in a man's life, he said, when he might properly consider himself the centre of attraction—at his christening, at his marriage, at his own funeral. This, the beginning of his thirty-sixth course of lectures on anatomy, was the end of his connection with the school. For about half of this time he had also taught physiology, but with the growth of the science he had gladly given it over to form a new department. It was a good thing for a college to get rid of her old men. Their ideas were antiquated and the college had better let them go. He had held his office so long because he taught a subject which could never become antiquated. In his lifetime it had received very few important additions. He had begun the study of law in his youth as an experiment, but for various reasons had turned his attention to medicine. While in the law school he had engaged with some friends in publishing a paper and for the first time saw himself in print. From the printer's type he had contracted the disease of authors, head-poisoning, which he had never quite got rid of. The doctor finished with some practical remarks on the way in which the science was tending.

**ANNUAL REPORT OF THE NATIONAL BOARD OF HEALTH.**—The fourth annual report of the National Board of Health was transmitted to the Secretary of the Treasury on the 29th ult. Among the papers promised, as appendices to the report, are the details of Prof. Mallet's work on "Water Analysis," an abstract of which has already appeared as a supplement to the now suspended *Bulletin*; Philbrick and Bowditch on the "Siphonage of Traps," Bowditch's "Survey of Summer Resorts," Wood and Forman "On the Relations of Diphtheria to other Septic Diseases;" a second paper by Profs. Rumpelly and Smyth on "The Filtering Capacity of Soils," and the report of a Committee on the Registration of Vital Statistics, are also appended, and will be looked for by those interested in sanitary matters with considerable interest. In the last-mentioned paper the position is taken that there need be no difficulty in procuring in this country as complete a registration as is obtained in any other, and the suggestion is made that the State registering officers furnish the data to the general government, which, on its part, should agree to pay part of the expense of collecting them. The Board approves of this suggestion of the Committee, and recommends a special appropriation by Congress for this purpose.

The relations of the National Board of Health to maritime quarantine are clearly explained.

The law of June 2, 1879, usually referred to as the *quarantine law*, imposes certain duties on the Board in connection with quarantine, but conveys no quarantine powers. These powers are vested in the State and municipal authorities, and the duty of the Board is to aid these authorities in the execution of their rules and regulations for the prevention of the introduction of contagious diseases. Hence, the establishment of the Ship Island, Sapelo Sound, and Elizabeth River Stations as aids to the local authorities on the Gulf and Atlantic coasts. That a station of similar character is required near Galveston, Texas, seems manifest from the events of the past summer, but no recommendation is made to this effect, probably because this has already been done in previous reports. In referring to the history of a steamer which entered San Francisco harbor with smallpox among her Chinese passengers, the report remarks: "This particular case has reference only to smallpox, but when the devastation effected by cholera in Japan since April last, is considered in connection with the intercourse between Yokohama and San Francisco, and the railroad facilities between the latter port and the whole of the United States, the subject assumes a larger proportion, and in the event of inability in the part of State or municipal authorities to establish a local quarantine, a recommendation by this Board for the establishment of a refuge station on the Pacific coast seems called for by the general interests of the country."

The report urges that bills of health should be required of all vessels coming to the United States. This would have the beneficial effect of causing special attention to be paid to the condition of vessels at their ports of departure, in order that clean bills of health might be obtained by them, and would thus by so much lessen the number of vessels to be treated in the refuge stations and the local quarantine, and the chances of the importation of exotic contagious diseases. As the law stands, at present, a penalty is imposed upon vessels which enter upon our ports without bills of health, but this law cannot be enforced, as in the first place it throws upon this government the burden of proving the port of departure an infected one, and in the second, the law contains a proviso requiring its official promulgation in the ports of departure, and this official promulgation was not permitted by the Cuban authorities.

The inter-State inspection service on the Mississippi River is reported as having worked well during the past as during previous summers, in giving security to the people of the valley above New Orleans against the propagation of yellow fever from unsuspected or unreported cases in that city. Travel and traffic by river and railroad continued unchecked under the condition imposed by the States of the valley to wit: the certificate of a National Health Board inspector, that the vessel or train was free from the infection of yellow fever or from any reasonable suspicion of such infection.

The immigrant inspections which were instituted in June last, appear to come under the headings of both *maritime* and *inter-State quarantine*, for they involve inspections at the ports of entry, such as New York, Philadelphia, Baltimore, and Port Huron, as well as later inspections at certain large distributing railroad centres, such as Chicago, St. Louis, etc. These interior inspecting stations are needful, because the disease, smallpox, against the importation of which the inspections were instituted, has a period of latency which permits an immigrant who has been exposed at an European port before sailing to pass the quarantine inspector at the port of entry, and proceed undetected on his westward journey. The inspectors do not simply

look out for smallpox cases, and isolate, disinfect, and vaccinate in the event of their detection, but they examine all immigrants as to their protection by vaccination or previous attack, and if this is found to be unsatisfactory, protection is afforded by a fresh operation. The steamship managers and surgeons have cooperated with this service by having their immigrants inspected and vaccinated during the ocean passage. Boston has established inspections in accord with the work of the general service, but the Board has not been required to pay for them.

The suspension of the *Bulletin* is regretted, and its restoration recommended.

A few words only are given to the epidemics at Pensacola and Brownsville. It is noted in connection with the latter, and the attention of Congress is invited to the fact "testified to by those who are cognizant of the epidemiology of yellow fever in that section, that while an inspector of this Board was on duty at the mouth of the Rio Grande, the fever was excluded, although the conditions predisposing to invasion were as imminent during that period as they were at the time when the disease effected its entrance."

The report then defends the Board against the charges which have been made, that it has exceeded its authority. It shows that all the work which has been done comes directly under the provisions of the Acts of March 3 and June 2, 1879. It closes with an itemized, tabular statement of the expenditures since the organization of the Board, which shows that the charge of extravagance is equally unfounded. No part of the contingent fund of \$100,000 has ever been used by the Board. The first use of that fund was made by Surgeon-General Hamilton, at Brownsville.

The estimates for the continuance of the work of the Board, amount to \$150,000. A contingent fund of \$100,000, to be used in case of an epidemic, is also recommended.

**DIPHTHERIA IN PHILADELPHIA.**—The latest information with regard to the prevalence of diphtheria in Philadelphia shows that this disease is on the increase, and more generally distributed throughout the city. The decrease in the deaths noticed in our last issue was only an apparent abatement of the epidemic.

The number of deaths reported for the week ending December 2d was 42, an increase of 13 over the number for the preceding week, and 3 more than the greatest number recorded in any previous week during the year.

Deaths are reported in 20 out of a total of 31 wards. In the 23d Ward, or Frankford, with a population of 26,522, there were 7 deaths, against 4 in the preceding week. In this outlying district the disease has been most persistent from the start, and there appears to be no indication of its abatement. Quite a number of cases have occurred among the employés of the United States Arsenal, requiring the most rigorous measures to prevent its spread. The 24th Ward, also a semi-rural district, and widely separated from Frankford, also shows a marked increase in the number of cases and deaths. There was 5 deaths reported, against one in the preceding week.

The health officer reports 165 new cases for the week ending December 5th. These are unequally distributed among all the wards, with the exception of the 14th, which reports no cases during the week. This shows a very general prevalence of the disease, though, as might be expected, in some wards it has gained a much stronger foothold than in others. There are 21 new cases reported in the 24th Ward; 15 in the 29th; 12 in the 31st; 11 in the 20th; and 9 each in the 1st, 12th, 19th, 23d, and 28th Wards.

The total number of deaths for the year to Decem-



ber 3d, is 801. Of this number, 174 occurred in the first quarter; 163 in the second; 215 in the third; and 249 in the first nine weeks of the fourth quarter. The indications are that the last quarter of this year will show a far greater mortality from this cause than has ever occurred in the same period of time.

**THE COMPENSATION OF PRESIDENT GARFIELD'S SURGEONS.**—The claims allowed by the Garfield Board of Audit have just been made public. The physicians get \$27,500. Of this amount Dr. D. W. Bliss gets \$6,500; Dr. D. Hayes Agnew, \$5,000; Dr. Frank H. Hamilton, \$5,000; Dr. Robert Keyburn, \$4,000; Dr. Silas H. Boynton, \$4,000, and Dr. Susan A. Edson, \$3,000. The amount awarded for services and supplies was \$5,929.93. The items range from \$13 for express hire to \$1,500 for the Central Railroad of New Jersey. Under head of extra services by government employes the items range from \$15 to \$200, with a total of \$5,440. The grand total is \$38,869.93. The total appropriation to pay claims against the Garfield estate was \$57,500, of which amount \$35,500 was specially appropriated for physicians and medical attendance. It will be seen that the allowances for the physicians and medical attendance are \$8,000 less than the amount appropriated, and that the allowances for outside claims are about \$11,000 less than the amount available, making a total balance of nearly \$19,000 out of the entire appropriation of \$57,500.

**A FOREIGN HONOR TO DR. PARVIN.**—The Edinburgh Obstetrical Society has elected DR. THEOPHILUS PARVIN an honorary member.

**LIGATURE OF THE EXTERNAL ILIAC ARTERY FOR FEMORAL ANEURISM IN A CHILD.**—The English journals announce the occurrence, at the East London Hospital for Children, of a case of femoral aneurism in a boy twelve and a half years old, in whom the external iliac was tied on November 10; the case has as yet progressed favorably; the subsequent history is promised.

**THE "FAITH CURE" ESTABLISHMENT OF BUFFALO** has been broken up by reason of lack of funds. The inference is unavoidable that the power of faith may be equal to such a trivial work as the cure of disease, but is not equal to the more arduous task of raising a sufficient supply of money to keep the institution in operation.

**A DIRECTORY FOR NURSES IN TORONTO** has been established under the auspices of the Toronto Medical Society.

**PROF. VIRCHOW'S HEALTH.**—Our latest German exchanges announce a steady improvement in Prof. Virchow's health. He has been suffering for some time from an attack of acute nephritis, complicated by rheumatic neuralgia, and commencing with slight hemorrhage. He is now free from fever, and the amount of albumen in his urine is steadily declining.

**JEFFERSON MEDICAL COLLEGE.**—The trustees of Jefferson Medical College, Philadelphia, have elected DR. J. SOLIS COHEN Honorary Professor of Laryngology.

**SIR THOMAS WATSON.**—The latest English journals report that Sir Thomas Watson has been gradually growing weaker, and his sufferings have been increasing.

**A MALPRACTICE TRIAL IN MICHIGAN.**—In the suit of Wood vs. Barker, Mr. Justice Campbell, the other

justices concurring, of the Supreme Court, has just filed the following decision.

Plaintiff, who is a surgeon, sued defendant on his promise to pay for professional services rendered to one Murray, who had been injured by a blast, so that both legs were badly crushed below the knee. Plaintiff was called in as counsel to aid the attending surgeon Dr. Harding, shortly after the accident at Sault Ste. Marie. The left leg was amputated, and they were both of opinion that amputation of the other was expedient, by reason of the extensive comminuted fracture of the bones and laceration involving injury to an artery, to prevent extreme danger of death. The opposition of Murray to this prevented the amputation and the limb was ultimately saved but not entirely restored to its original condition. Some time after the plaintiff had ceased his visits and while the case was in the hands of Dr. Harding, aided by a nurse, Dr. Jessop, of Mackinaw, came over and was employed to treat the patient in connection with Dr. Harding. The only medical testimony in the case was given by plaintiff and Dr. Harding. Dr. Jessop was not sworn. The employment by defendant seems to have been shown, and the questions on which the controversy appears to have turned were the value of the services and the propriety of the treatment.

It is to be observed that there is no conflict of testimony whatever in regard to the fact of the work and attendance of plaintiff, and no testimony which did not leave a considerable sum due him if those services were properly rendered. The court in charging the jury told them in substance that they were at liberty, if not satisfied with the testimony of the experts, to use their own judgment on the question of value. They were also instructed that if plaintiff's course was unskillful, they might reduce the fees accordingly, as in their judgment should be deemed proper. They gave plaintiff nothing. There can be no presumption of law concerning the value of a surgeon's services and there is no presumption that a jury can ascertain it without testimony of some kind, from persons knowing something about such value. As already suggested there was positive testimony of value not discredited, and, in the case of Dr. Harding, given by a disinterested witness called for important purposes by the defendant himself. We can see no sufficient reason for the suggestion that all of this testimony might be disregarded, and there is no rule which would allow the jury to entirely ignore the testimony, and at the same time to form an independent conclusion without testimony upon a matter which required a proof beyond their conjecture or their opinion. We do not say that the value of a physician's services at a given time and place may not be known to other persons than physicians, if they have been in a position to learn the customary or proper rates. But there is no legal presumption and no reasonable probability that all jurymen have this knowledge. And there can be no safety to any one if juries are to use their own unguided views on such matters.

Neither was there any evidence which would justify the jury in reducing the otherwise appropriate compensation on the ground that plaintiff's treatment was improper. There was no such evidence. The fact that the injured limbs were slow in healing and imperfectly healed at last does not necessarily show that the treatment was improper. The injuries as described were of a very aggravated nature, and beyond any ordinary fracture, the limbs being bruised and badly lacerated, the bones crushed, and an artery torn. Both medical witnesses were of opinion that there was danger in leaving the right leg on. There is nothing to show that the course taken under plaintiff's oversight was not the proper one, and nothing to show that when he left the case in the hands of the regular

surgeon and nurse, anything necessary had been omitted or anything done out of the way. On the contrary, not only the plaintiff, but Dr. Harding gave positive testimony the other way. There is nothing to show that plaintiff did not possess and use competent skill. The fact that some time later Dr. Jessop made some change in the management of the remaining limb had no tendency to show that the previous treatment was not proper at the time, and no one testifies it was not. Dr. Harding's testimony indicates entire harmony of views, and Dr. Jessop is not produced to contradict him. No other medical testimony is offered to show any failure of skill or any mistake in the treatment.

Where all the testimony in the case is in favor of the treatment pursued, and the question is one of medical skill which can only be tested by those familiar with such matters, it was error to let the jury draw adverse conclusions, which could only be based on their unprofessional notions of how such injuries should be treated. The fact that Murray survived is not evidence that his case was not desperate in appearance or in fact, and the fact that his limb is not restored to perfect soundness is no proof that he has been maltreated. The jury could not rightly be allowed to find malpractice without testimony from persons who were qualified to give opinions on the methods of treatment.

The judgment must be reversed with costs, and a new trial granted.

**DR. C. R. AGNEW ON THE NEW CODE.**—DR. AGNEW, of New York, has addressed a letter to the *Louisville Medical News* in response to its strictures on the new Code. He says "Much had been done, it is true, in earlier days by our profession to protect the public, and the old Code had in its day been of great value as one of the few safeguards. But when the population of the country began to grow with marvellous rapidity, and heterogeneous social elements to pour in upon every community, the medical profession with its proscriptive code could do very little that was effective to oppose the tide of charlatany and medical incompetency. It could do much in its medical schools to advance the standard of education, and thus supply more and better physicians; but the agency of the State came to be more essential in mitigating the evils of quackery and medical incompetency, and in providing and enforcing sanitary laws.

"I have thus, in a few words, hinted at what I believe to be the ruling motives which influenced our State Society to act. And furthermore, many of its members believed that the tone of the profession would be vastly improved if liberty of conscience and judgment were fully accorded to the members of the only one of the three learned professions still not fully in possession of it. And this idea was very influential in forming the new Code and in its adoption by the Society.

"You may ask what do we expect will follow practice under our new Code? Less acrimonious criticism of legally qualified doctors; more careful study of those things which will raise the standard of medical education and character; more activity in those fields of State and national politics which include the great sanitary interests of the people; more vigilance in pursuing medical outlaws; more diffusion of light to educate the people, to lessen irrational credulity, and to reveal the tricks of incompetent or dishonest medical practitioners. It will force us, as a profession, to combine with legislators to protect the people, and become a greater factor in social and sanitary questions."

Dr. Agnew unfortunately fails to point out how the new Code is going to influence these reforms, and this last defence is not likely to make a single convert. In an editorial comment on the letter the *Louisville Medi-*

*cal News* says: "We imagine the thoughtful reader will find no little difficulty in following Dr. Agnew through the premises which seem to have led him to the conclusion that to protect the public from quackery the medical profession should take the quacks into fellowship, and thus publicly recognize them as physicians worthy of confidence and affiliation. We can conceive no proposition more absurd. And again, our metropolitan *confrère*, admitting that the Code of Ethics of the American Medical Association has, 'in its day,' been of great value as a safeguard to protect the public from quackery, claims that now the population of the country has so increased that it has become ineffective. It must be remembered that the question under consideration is one of ethics, and it must be conceded that what is right in a country of two millions is equally right and just in a population of fifty millions. The great principles of ethics and morals are immutable, and are altered neither by longitude nor latitude, nor by growth of a population in heterogeneous elements. Our correspondent's explanation of the motives of the New York State Medical Society which led to a departure from the Code of Ethics will scarcely satisfy the thoughtful reader of his letter."

**CHOLERA PROSPECTS.**—DR. PROUST, in a note on the present situation of Southern Europe, with regard to cholera, points out that to pass from India to Europe cholera has heretofore followed two routes. The first in 1823, 1830, and 1847, was the land route from Afghanistan, Persia, and the Caspian Sea. The second is the sea route followed by the epidemic of 1865, viz., by the Red Sea and through Egypt. At the present time the land route does not appear to present any dangers for Europe, but the case is somewhat different as regards the other. Last year the presence of cholera among pilgrims at Mecca exposed Europe to great dangers, and the Egyptian troubles gave rise to very considerable alarm, owing to the proposed reinforcement of the Egyptian army by troops coming from India; this led to the French Government calling the attention of the English foreign office to the desirability of taking special measures to keep out cholera from the Red Sea.

At present all fears of importation by troops coming from India are dissipated. There has not been any cholera in Egypt nor anything resembling it, but cholera exists in many points in the extreme east, in Japan, in the Philippine Islands, in Java, in Sumatra, and in India. This, however, has been the usual condition for the last twenty years; the real danger is in the Red Sea, and is due at present to the Mecca pilgrimage. Cholera, in fact, has appeared on the ship *Hesperia* from Bombay, with a cargo of five hundred pilgrims. This ship was given a clean bill of health, on the ground that cholera was not epidemic at Bombay, there being only some isolated cases there. This, Dr. Proust insists, was a grave error, the danger of the importation of cholera having no relation to the quantity of the disease at the port of the departure, but rather to the character of the emigrants.—*Sanitary Engineer*, Nov. 16, 1882.

**IMMIGRANT INSPECTION SERVICE IN THE WESTERN DISTRICT DURING OCTOBER.**—From the monthly report of Dr. J. H. RAUCH, the Supervising Inspector of the National Board of Health Immigrant Inspection Service, we learn that of the immigrants arriving in the district during the month, 16,473 were inspected by the Assistant Inspectors, who found 3,353, or about one-fifth of the whole number, whom they deemed it desirable to vaccinate or revaccinate. Among these were 350 who had never been vaccinated at all, and these included an unusually large number of adults.

Of the total number (16,473) of immigrants inspected

in this district during the month, 4,728, or nearly 30 per cent., were susceptible on landing; but 1,364 of these were vaccinated or revaccinated by Eastern inspectors before arriving in the Western District. If this proportion holds good with the total number of immigrants arriving in the country, then only a little over one-third of the susceptible are properly protected in the Eastern inspection districts. This may be due to the reduction in the number of inspectors last month, but it is also probable that the inspectors pay more attention to the immigrants who settle down in their respective districts, and only vaccinate as many of those going beyond their boundaries as they find time and opportunity for.

There have been seven cases of smallpox removed from trains during the month. The first six cases were removed to the Chicago smallpox hospital, and the remaining one, which was discovered at East St. Louis on the Indianapolis & St. Louis Railroad, was taken to the St. Louis quarantine hospital. The infected cars were side-tracked and thoroughly cleansed and disinfected, and all exposed individuals were at once vaccinated.

**SMALLPOX IN SOUTHERN AFRICA.**—This disease, which has been exceedingly virulent at Cape Town for some time back, has made its appearance at St. Paul de Loanda on the south-west coast. During September, the first month of its presence, there were 178 cases reported, of which 95 proved fatal. The government is taking active steps to meet the disease and restrain it. Vaccination has been made compulsory, and the vaccinating surgeons are supported by a body guard from the Portuguese military forces.

**HEALTH IN MICHIGAN.**—Reports to the State Board of Health for the week ending November 25, 1882, indicate that influenza, diphtheria, and inflammation of the bowels have increased, and that puerperal fever, dysentery, and cholera morbus decreased in area of prevalence.

Including reports by regular observers, and others, diphtheria was reported present during the week ending November 25, and since, at 22 places, scarlet fever at 13 places, and measles at 5 places. Smallpox was reported at Grand Rapids, November 25.

**OBITUARY RECORD.**—At Newark, N. J., of heart disease, on November 28, in the sixty-first year of his age, ALEXANDER N. DOUGHERTY, M.D., late President of the New Jersey State Medical Society.

Dr. Dougherty was born in Newark, on January 1, 1822. He was educated at Oberlin College, and received his medical degree from the College of Physicians and Surgeons of New York, in 1845. In 1861, he was commissioned a Surgeon of Volunteers, and was made Medical Director of the 2d Army Corps, and subsequently of the Right Grand Division (2d and 9th Corps) of the Army of the Potomac. He was wounded in the battle of the Wilderness. At the close of the war he was mustered out of the service with the rank of Brevet-Colonel. In 1866, he was appointed Postmaster at Newark, and served for two years. He was formerly President of the Essex County Medical Society, and in 1880 he was elected President of the State Medical Society. He was Surgeon and Commandant of the New Jersey Home for Disabled Soldiers, at Newark; and Surgeon to St. Michael's Hospital, Newark. The Essex County Medical Society adopted appropriate resolutions on the death of their late President. Dr. Dougherty's funeral was attended by General Hancock and staff, General Campbell and staff of the New Jersey Grand Army of the Republic, the various Grand Army posts of Newark and Orange, and the

inmates of the Soldiers' Home at Newark, besides various societies.

—DIED in New York, on December 2, 1882, in the forty-fifth year of his age, DR. JOHN PHILLIPS PAYSON WHITE, M.D., attending surgeon to Bellevue Hospital. Dr. White was born in Southampton, July 4, 1838. He graduated in the arts at Williams College, and later in medicine at the College of Physicians and Surgeons in New York. When the Rebellion broke out, he accepted a commission as Assistant Surgeon of the 9th New York Volunteer Infantry. He was soon made a surgeon, and in the latter part of the year was appointed medical purveyor of the Army of the Potomac. He accompanied General Burnside on his expedition to the Carolinas, and on returning entered the 10th New York Volunteers. He was temporarily Medical Director of a division of the Army of the Potomac, and subsequently was made Assistant Surgeon-General, with the rank of Lieutenant-Colonel. He was consulting physician of the Women's College, and a member of the New York State Medical Society and Academy of Medicine.

**RESOLUTIONS OF THE RAMSEY COUNTY MEDICAL SOCIETY ON THE DEATH OF DR. WHILLDIN.**—At a meeting of the Ramsey County Medical Society, the following action was taken with reference to the death of DR. WHILLDIN, of Saint Paul.

*Whereas*, Our friend and associate, DR. JOHN S. WHILLDIN, has been suddenly removed by death; and

*Whereas*, Even during his brief residence among us he had greatly commended himself to our esteem by his upright character, his uniform courtesy and kindness, and his many engaging qualities; therefore, be it

*Resolved*, That in Dr. Whilldin we recognize the traits which justly entitle him to be remembered as a sincere friend, a thoroughly competent physician, and a Christian gentleman.

*Resolved*, That in Dr. Whilldin's death we have not only suffered personal loss, but that our Society and profession have been deprived of one who promised to contribute materially to their success and usefulness.

*Resolved*, That these resolutions be published in the *Pioneer-Press* of this city, and in the *MEDICAL NEWS*, of Philadelphia.

#### OFFICIAL LIST OF CHANGES OF STATIONS AND DUTIES OF OFFICERS OF THE MEDICAL DEPARTMENT, U. S. ARMY, FROM NOVEMBER 27 TO DECEMBER 4, 1882.

CALDWELL, DANIEL G., *Captain and Assistant Surgeon*.—Leave of absence granted in Special Orders, No. 105, Oct. 3, 1882, Department of the Platte, extended three months.—S. O. 279, A. G. O., December 1, 1882.

POWELL, J. L., *Assistant Surgeon*.—Relieved from temporary duty as attending surgeon at headquarters Department of Texas, and to proceed to Fort Davis, Texas, and report to the commanding officer for duty.—S. O. 129, Department of Texas, November 23, 1882.

GRAY, WILLIAM W., *First Lieutenant and Assistant Surgeon*.—The leave of absence granted on surgeon's certificate of disability, October 31, 1882, Department of the South, is extended five months on surgeon's certificate of disability.—Pur. 3, S. O. 278, A. G. O., November 29, 1882.

THE MEDICAL NEWS will be pleased to receive early intelligence of local events of general medical interest, or of matters which it is desirable to bring to the notice of the profession.

Local papers containing reports or news items should be marked. Letters, whether written for publication or private information, must be authenticated by the names and addresses of their writers—of course not necessarily for publication.

All communications relating to the editorial department of the NEWS should be addressed to No. 2004 Walnut Street, Philadelphia.